DEPARTMENT OF HEALTH AND HUMAN SERVICES					CENTERS FOR MEDICARE & MEDICAID SERVICES			
					AND TRANSMITTAL	ID: WSUP		
		1			TE SURVEY AGENCY	Facility ID: 00335		
1. MEDICARE/MEDICAID PROVIDER (L1) 245604	R NO.	3. NAME AND AL (L3) AUBURN M		CILITY		4. TYPE OF ACTION: 7 (L8)		
2.STATE VENDOR OR MEDICAID NO).	(L4) 501 OAK ST				1. Initial2. Recertification3. Termination4. CHOW		
(L2) 422243100		(L5) CHASKA, M	1N		(L6) 55318	5. Validation 6. Complaint		
5. EFFECTIVE DATE CHANGE OF O	WNERSHIP	7. PROVIDER/SU	PPLIER CATEG	ORY	<u>02</u> (L7)	7. On-Site Visit 9. Other		
(L9)		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	8. Full Survey After Complaint		
6. DATE OF SURVEY 09/08/2		02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	FISCAL YEAR ENDING DATE: (L35)		
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/III		12/31		
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/51		
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED	AS:				
From (a):		X A. In Complia	nce With		And/Or Approved Waivers Of	The Following Requirements:		
To (b):			equirements e Based On:		2. Technical Personnel	6. Scope of Services Limit		
12.Total Facility Beds	61 (L18)	-	cceptable POC		3. 24 Hour RN 4. 7-Day RN (Rural SN	7. Medical Director F)8. Patient Room Size		
					5. Life Safety Code	9. Beds/Room		
13.Total Certified Beds	61 (L17)		pliance with Prog ents and/or Appli		* Code: A *	(L12)		
14. LTC CERTIFIED BED BREAKDOW	٧N				15. FACILITY MEETS			
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
61 (L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMA	RKS (IF APPLICA	BLE SHOW LTC CA	NCELLATION	DATE):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:		
Shawn Soucek, HPR S	SWS	0	9/17/2015	(L19)	Mark Meeth, Enforcement Specialist 12/04/2015 (L20)			
PAR	T II - TO BE	COMPLETED I	BY HCFA RE		L OFFICE OR SINGLE S			
19. DETERMINATION OF ELIGIBILI			IPLIANCE WITH			ncial Solvency (HCFA-2572)		
X 1. Facility is Eligible to Pa			ITS ACT:	1 OI VILL	2. Ownership/Contro	l Interest Disclosure Stmt (HCFA-1513)		
2. Facility is not Eligible	neipate				3. Both of the Above	· · · · · · · · · · · · · · · · · · ·		
	(L21)							
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	/IENT	26. TERMINATION ACTION:	(L30)		
OF PARTICIPATION	BEGINNING	J DATE	ENDING DA	ГЕ	VOLUNTARY 00	INVOLUNTARY		
08/01/1992					01-Merger, Closure	05-Fail to Meet Health/Safety		
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse	oo ran to meet ngreenient		
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	OTHER		
	A. Suspensio	n of Admissions:	(1.4.4)		04-Other Reason for withdrawar	07-Provider Status Change 00-Active		
(L27)	B. Rescind S	uspension Date:	(L44)			00 neuve		
			(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS			
		03001						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	20	. DETERMINATION		DATE				
51. KO KLULII I OF CI/15-1557	52	09/10/2015		DITE .				
	(L32)			(L33)	DETERMINATION APPE	ROVAL		



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



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 Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245604	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 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	(1	'5) [Date
		Correction			Correction				Correction
		Completed			Completed				Completed
ID Prefix	F0221	09/08/2015	ID Prefix	F0246	09/08/2015	ID Prefix	F0371		09/08/2015
0	483.13(a)	_		483.15(e)(1)	-		483.35(i)		_
LSC		-	LSC			LSC			-
		Correction			Correction				Correction
ID Prefix	F0425	Completed 09/08/2015	ID Prefix	F0441	Completed 09/08/2015	ID Prefix			Completed
									_
Key. #	483.60(a),(b)	-		483.65		Reg. #			-
		-							
		Correction			Correction				Correction
		Completed			Completed				Completed
ID Prefix		_	ID Prefix		-	ID Prefix			_
Reg. #			Reg. #			Reg. #			
LSC		-	LSC			LSC			-
		Correction			Correction				Correction
ID Prefix		Completed	ID Prefix		Completed				Completed
		_			-				_
Reg. # LSC		_	Reg. #		-	Reg. #			-
		-							
		Correction			Correction				Correction
		Completed			Completed				Completed
ID Prefix		_	ID Prefix		-	ID Prefix			_
Reg. #		_	Reg. #		_	Reg. #			_
LSC		-	LSC		•	LSC			_
Reviewed By	Reviewed	Ву	Date:	Signature of Surve	eyor:			Date:	
State Agency	, GL/r	nm	09/17/20	15	3092	3		09/08	/2015
Reviewed By	Reviewed	Ву	Date:	Signature of Surve	yor:			Date:	
CMS RO									
Followup to	Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of				•		
	7/16/2015			Uncorrecte	d Deficiencies	(CMS-2567) Sent	to the Facility?	YES	NO



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.

Auburn Manor November 16, 2015 Page 2

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).

Auburn Manor November 16, 2015 Page 3

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

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				IO. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	· · · ·	E SURVEY IPLETED
		245604	B. WING		0.	7/16/2015
NAME OF PI	ROVIDER OR SUPPLIER	I	<u> </u>	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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		FO	00		
F 246 SS=D	as your allegation of o Department's accepta enrolled in ePOC, you at the bottom of the fi form. Your electronic be used as verificatio Upon receipt of an ac on-site revisit of your validate that substant regulations has been your verification. 483.15(e)(1) REASO OF NEEDS/PREFER A resident has the rig services in the facility accommodations of in	ance. Because you are ur signature is not required rst page of the CMS-2567 e submission of the POC will n of compliance. Exceptable electronic POC, an facility may be conducted to tial compliance with the attained in accordance with NABLE ACCOMMODATION ENCES ht to reside and receive with reasonable	F2	46		8/25/15
	the individual or other endangered. This REQUIREMENT by: Based on observatio review the facility faile within reach for 1 of 2 for environmental cor Findings include: On 7/13/15, at 2:45 p on her back with the	r residents would be is not met as evidenced n, interview and document ed to ensure a call light was 2 (R21) residents reviewed		Auburn Manor respects each reright to reside and receive servi facility with reasonable accomm of individual needs and preference except when the health or safet individual or other residents wo endangered. The survey team cited one instatthey 0bserved R21's call light to	ices in the nodations nces, ay of the uld be ance when	
	signuy, watching a te	REVISION. THE CAILINGIN WAS				
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE	1	TITLE		(X6) DATE
Electroni	cally Signed					08/06/2015

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.

PRINTED: 11/16/2015

							O. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				1 Y Z	E SURVEY IPLETED
		245604	B. WING			07	7/16/2015
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
AUBURN	MANOR				1 OAK STREET HASKA, MN 55318		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETIO DATE
F 246	Continued From page	e 1	F 24	46			
1 240	next to her on the bed locate with verbal cue Later that evening at room sitting in her wh The doors to her room resident could be visu She was dressed in a brief and her bare leg the chair leg rest. She bed with her left hand the resident's reach o wheelchair. At 7:17 p. came into the room a could do to help. With the NA hurriedly left F right back." At 7:20 p. hall with a second NA R21's room, the two N resident room. At 7:28 p.m. the surve nurse (RN)-A to obse light. RN-A picked up should not have been reach. She explained probably threw it off h pinned it on her chair, RN-A said R21 proba call light effectively, a	d, which she was able to as from the surveyor. 7:14 p.m. R21 was in her eelchair next to her bed.	F 24	40	floor and out of reach of the resident. resident is known to become restless a will throw her call light on the floor at times. Contributing factors to this find includes the call light's cord clip failing from, what more than likely was, the fo of the resident's pulling on the cord an throwing it. This was an isolated even supported by the number of other time the surveyor described the call light be within the resident's reach as noted in example. This event was incidental in nature and not a result of a failed prace or facility system. Residents' call light being within reach is the standard of c at Auburn Manor and all staff understa the importance and necessity of this. The call light cord clip was replaced immediately upon its discovery and ha been noted to be functioning properly during the remainder of the survey, ag as noted throughout the surveyor's example. Facility Wide Response Addressing Of Residents With the Potential to be Affected: 1. Facility staff will be provided a remin of the necessity to ensure that resident	and ing orce d t es bing the tice s are and id tain ther	
		A said R21 was admitted cture, and had experienced			call lights are always within the resider reach. This will be accomplished usin the facility's electronic learning system	g	
	the hospital. The initia	had been experiencing			2. Charge nursing personnel will be responsible for ongoing compliance of lights being within reach by doing visu monitoring of resident room's for		

Facility ID: 00335

If continuation sheet Page 2 of 16

		MEDICAID SERVICES			OMB NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245604	B. WING		07/16/2015
AME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
UBURN	MANOR			501 OAK STREET CHASKA, MN 55318	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETIC
F 246	Continued From page	2	F 246	5	
	state often associated fluctuating cognition.			appropriate call light placement	
	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.			3. Ongoing: Quarterly random audits of correct call light placer be conducted utilizing the facilit Resident and Room Safety Aud (Appendix E). Data obtained fr quality assurance process will b reviewed, with recommendation intervention made, during the q quality assurance meetings for than one year.	ment will y's lit Tool rom the be is for uarterly
	(DON) was interviewed residents who were u would have been out can see themstaff s if they have any need bed during the daytim expect that to show in to be in the policy. Sp be in the care plan." A light audits had been would need to speak maintenance, "becau technical side." Since of director of nursing had not performed an	a.m. the director of nursing ed. She explained that nable to use their call lights of their rooms "where staff should round on them to see is during the night, or naps in ne." She added, "I would in the care plan. It's not likely becific rounding times should When asked whether call performed she said she to the director of se he does more of the she took over the position 5/18/15, DON stated she by call light audits. The DON cted staff to follow facility			
	policies. In addition, be placed in reach of use them. When aske plans to indicate whe the call light she resp	cted staff to follow facility she expected call lights to residents who were able to ed if she would expect care ther a resident could not use onded, "No, I have not had usemy thought is that they			

Facility ID: 00335

If continuation sheet Page 3 of 16

		ND HUMAN SERVICES MEDICAID SERVICES				FORM): 11/16/201 I APPROVE . 0938-039
TATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE : COMPL	
		245604	B. WING			07/1	16/2015
NAME OF PF	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				50	1 OAK STREET		
AUBURN I	MANOR			CI	HASKA, MN 55318		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 371 SS=F	Continued From page STORE/PREPARE/S		F	371			
	Considered satisfacto authorities; and (2) Store, prepare, di- under sanitary condit This REQUIREMENT by: Based on observatio review, the facility fail ensure that sanitation dishwashing process dishwasher temperat failed to ensure that f were kept clean and This had the potentia that resided in the fac Findings include: On 7/14/15, at 9:56 at the kitchen, a dietary running dishes throug tank temperature was Fahrenheit (F), the rin degrees F and the fin 132 degrees F. DA-A loads of plates throug	T is not met as evidenced on, interview and record led to follow procedures to an occurred during the and consistently monitor ures. In addition, the facility freezers and refrigerators that opened food was dated. I to affect all 60 residents		S	Auburn Manor does procure food fro sources approved or considered satisfactory by Federal, State and loc authorities and stores, prepares and distributes that food under sanitary conditions. On 7/14/15, the survey team noted the the dishwasher in the kitchen was no heating to required temperatures. The facility's dietary manager was consult 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 die aid stated that she was nervous with survey process and forgot to turn on booster heater. Once the booster he was turned on and the water temperatures reached required levels	eal t t ted etary the the ater	
	sent through the dish	ime, DA-B was taking dishes machine and began storing rveyor intervened and asked			dishes that would have been affected the water temperatures not reaching required levels were re-washed at the	l by	

Facility ID: 00335

If continuation sheet Page 4 of 16

CENTER	S FOR MEDICARF &	MEDICAID SERVICES				OMB N	M APPROV O. 0938-03	
TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		CONSTRUCTION	(X3) DAT	E SURVEY	
		245604	B. WING			07	7/16/2015	
NAME OF P	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE	1 0.		
				501 OAK STREET				
AUBURN	MANOR			СН	ASKA, MN 55318			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE	
F 371	Continued From pag	e 4	F 3	71				
		ishwasher temperature			proper temperatures. This was direct	ed		
	gauge and verify it w	•			by the facility's dietary manager and r			
	required temperature				the surveyor as stated in the example			
	Following the observ	ation, DA-A stated that she			In response to the above findings, the	4		
		temperatures to be between			dietary manager is personally training			
		d the final rinse temperatures			each new dietary team member on tu			
		rees. DA-A reported she had			on the booster heater and making sur	•		
	checked the tempera	atures "this morning before			is on for each shift. In addition, the di			
	breakfast and the ma	achine was working okay."			manager has re-trained her staff on			
					checking dishwasher temperatures ev			
		a.m. the dietary manager			shift and report irregularities to the die	-		
		e dishwasher temperatures			manager immediately. In addition, the			
		for the wash cycle and 132			dietary manager monitors the temper	ature		
	-	al rinse. DM stated that "the " The DM then checked on			logs for completion daily.			
		ied that it had been turned			During the initial tour of the kitchen, o	n		
		ooster on and asked DA-A to			7/13/15 at 12:59 p.m., the outside			
		ugh the dishwasher machine.			environmental temperature was in the	;		
		mpty trays, the wash			mid-ninety degrees Faherenheit with			
	temperature was rec	orded at 152 degrees F and			dew point of 72 degrees Faherenheit.			
		degrees F. The surveyor			The facility's roof-top air conditioning			
	-	ishes previously washed be			was being replaced that day resulting			
	re-washed at the pro	per temperature.			the kitchen being warmer and more h	umid		
	The 7/15 dish mach	ine temperature log was			that normal conditions. This was an isolated event of over 20 years, since	the		
		, at 1:13 p.m. The log			unit was the original cooling unit for th			
		es were supposed to have			part of the building. The administrato			
		times daily at breakfast,			toured the walk-in freezer after being			
		ta was unrecorded for three			summoned by the dietary manager			
	-	our days for lunch and seven			regarding the surveyor's concern. Th			
		een 7/1 and 7/13/15. The DM			was some mild frosting of on the base			
		encies in monitoring of the			one fan guard. The area measured 1			
	dishwasher temperat	lures.			inches with no thickness. There was ice build-up and no ice was blowing o			
	During a follow-up in	terview on 7/15/15, at 12:57			the contained food boxes. The frost of			
		d all dietary employees had			the thermometer disseminated by sim			
		g dishwasher and how to log			placing a finger on the face of the			
	temperatures. Here				thermometer. The finding was remedi			

	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		245604	B. WING		07	//16/2015
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	01	/10/2015
				501 OAK STREET		
AUBURN	MANOR			CHASKA, MN 55318		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO		(X5) COMPLETIO
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPF DEFICIENCY)		DATE
F 371	Continued From pag	e 5	F 37	1		
		temperatures be logged		later in the afternoon when the ne	W	
	every shift and irregu			roof-top unit was operational. Thi		
		OM further explained that the		was an isolated event which was	e meng	
	5	ed to have been turned on in		unavoidable upon analysis of cau	sative	
		ing any dishes through the		factors.		
	dishwasher, and the	n was to be turned off at				
	night.			The freezer/refrigerator near the		
				kitchenette area referenced in the		
	•	on 7/16/15, at 10:34 a.m. the		example to have an orange juice	•	
		nce stated the hot water		frosted freezer on 7/15/15 was an		
	booster was turned of	et at 160 degrees. If the		finding which posed no immediate risks. The facility does have a	enealth	
		e water would not heat to the		Refrigerator Cleaning Policy and		
		s temperature for the final		Procedure which speaks to cleani	na the	
	rinse.			refrigerators on a 'as needed rout		
				The frost build-up on the commun	-	
	The Hatco Corporati	on Electric Booster Water		freezer may have resulted from		
	Heater's Installation	and Operation Manual dated		miscommunication between nurs	ing and	
		Turn on the booster water		maintenance staff as to the need		
		oster water heater has had		freezer to be defrosted. When thi		
		e, operate the rinse cycle		was brought to facility staff's atter		
		temperature and pressure		maintenance staff removed the ur	nit to	
		ges. Water temperature at ould be 185-190 degrees F		have it defrosted.		
	(85-86 degrees Cent			Facility Wide Response Addressir	a Other	
				Residents With the Potential to be		
	On 7/13/15, at 12:59	p.m. during the initial kitchen		Affected:		
		rds, thermostat and some				
		chen walk-in freezer were		1. In addition to the dietary mana	ger's	
		uild up. The fans were		immediate response to the		
	-	ver the food boxes. The DM		aforementioned findings, the dieta	•	
	verified the findings	at the time of the observation.		manager will continue to personal	-	
	0- 74545 10.00			each new dietary team member o	-	
	On 7/15/15, at 9:39 a			on the booster heater and making		
		urse's desk/kitchenette area,		is on for each shift. In addition, th	-	
		l had not been wiped clean f of the refrigerator. The		manager will continue to train her checking dishwasher temperature		
		of the refrigerator was		shift and report irregularities to he	-	
	sman neezer on top	or the reingerator was		and report inegularities to he		1

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PRINTED: 11/16/2015 FORM APPROVED

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245604 B. WING 07/16/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **501 OAK STREET** AUBURN MANOR CHASKA, MN 55318 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 371 Continued From page 6 F 371 findings were verified by a registered nurse manager will continue to monitor the (RN)-A at the time of the observation. RN-A temperature logs for completion daily. stated that night shift was responsible for deep cleaning of refrigerator, "but it's a communal 2. The facility's Refrigerator Cleaning responsibility" to make sure the refrigerator was Policy and Procedure has been updated kept clean. RN-A stated that she did not know to include the defrosting of the communal who was responsible for defrosting the freezer. kitchenette refrigerator at least every six months and as needed. The defrosting of During interview on 7/15/15, at 10:32 a.m. the the freezer has been added to the director of nursing (DON) stated that she did not automated electronic (TELS) know who was responsible for defrosting the maintenance preventative maintenance freezer, but said "I will check and let you know." schedule. The health unit coordinator will The DON stated her expectations were that staff be responsible for the day to day will cleaned the freezers and refrigerators as per monitoring for everyone's compliance with the schedule and as needed. The following day at the requirements of the sanitation of the 12:50 p.m. the DON stated that she did not have refrigerator/freezer. "anything written down" but the maintenance 3. Ongoing: Quarterly random sample director usually defrosted the freezer every six audits of dishwasher temperatures and months. the kitchenette refrigerator/freezer The undated Auburn Manor Refrigerator Cleaning sanitation will be conducted and Policy and Procedure indicated, "Refrigerators in incorporated into the facility's quality resident's rooms, kitchenette area, and med assurance program. Data obtained from [medication] room will be cleaned as needed the quality assurance process will be routinely to reduce the spread of infection." reviewed, with recommendations for intervention made, during the quarterly quality assurance meetings for not less than one year. F 425 F 425 483.60(a),(b) PHARMACEUTICAL SVC -8/25/15 SS=D 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.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES.

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DEPARTMENT OF HEALT				FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	B. WING		07/16/2015
NAME OF PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZIP CODE	
AUBURN MANOR			501 OAK STREET CHASKA, MN 55318	
PREFIX (EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 425 Continued From	page 7	F 42	5	
A facility must pro (including proced acquiring, receivi administering of a the needs of eac The facility must a licensed pharm on all aspects of services in the fa This REQUIREM by: Based on observ review, the facility medication from a manufacture's gu whose inhaler ad Findings include: R61's Symbicort administered on medication assiss inhaler as require asked R61, "Are from the inhaler a TMA-A then shoo waiting in betwee puff to R61 who ti TMA-A had not in prior to breathing following the two minute between	ovide pharmaceutical services ures that assure the accurate ng, dispensing, and all drugs and biologicals) to meet n resident. employ or obtain the services of acist who provides consultation the provision of pharmacy		It is the policy, and intention, of Auburn Manor in Chaska to be in full compliar with all regulations and requirements of both the Medicaid and Medicare programs. These plans and responses the findings are written solely to maint certification in the Medicare and Medic Programs and, as required, are submit as the facility 's CREDIBLE ALLEGATION OF COMPLIANCE. This written response does not constitute a 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 dispute these findings in their entirety should any remedies be imposed.	nce of s to ain caid tted s n of n t to

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DEPARTMENT OF HEALTH AND HUMAN SERVICES. FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245604 B. WING 07/16/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **501 OAK STREET** AUBURN MANOR CHASKA, MN 55318 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 425 Continued From page 8 F 425 medication. residents, or obtains them under an agreement described in ¿483.75(h) of this Following the observation TMA-A stated, "I think I part. The facility does permit unlicensed am to wait 30 seconds before administering the personnel to administer drugs as second puff...That's how I was showed to give it." permitted by State law, under the general supervision of a licensed nurse. On 7/14/15, at 10:12 a.m. a licensed practical nurse (LPN)-A was asked about R21's inhaler. Resident #61 has a long-standing history medication. She reported, "I normally wait about of controlling his asthma with Symbicort. one minute before each puff of the inhaler. LPN-A He has been receiving the Symbicort also stated, "The TMAs usually give the inhaler since his admission last January. inhalers...I instruct the resident to breathe out Resident #61 is very familiar with the before breathing in the inhalation and hold breath inhaler administration protocol. He does for as long as they can." not require daily reminders of when to breathe in, when to hold his breath and At 10:14 a.m. director of nursing stated, "I would when to exhale as someone new to the expect TMAs to know how to give the inhaler by protocol or someone with a cognitive the packaging or from notes." impairment may. Those basic instructions are not appropriate or dignified for R61. When asked for a policy regarding inhalers on His MDS scores in Section C would 7/15/15, at 9:22 a.m. the director of nursing support his cognitive function and ability to stated she expected staff to follow manufacture's understand a consistent medication guidelines when administering inhalers. administration protocol without repeated elementary instructions of when to The undated Orally Inhaled Medications policy breathe in and when to breathe out. directed the staff to "Explain steps to resident: Resident #61's MDS Section C accompanies this document (Appendix F). Have resident exhale fully--shake unit to disperse medication--place mouthpiece in front of mouth or in mouth according to manufacturer's Upon further review of the manufacturer's recommendations--while inhaling slowly and instructions found at their website, deeply through mouth, depress medication https://www.mysymbicort.com/asthma/sy canister fully. Have resident hold breath for 10 mbicortinhaler/symbicort-inhaler.html, the seconds OR as long as possible OR according to only time required between puffs of manufacturer's recommendations. Have resident symbicort is the time required to re-shake exhale through pursed lips...Wait approximately 1 the inhaler, which the TMA did. The TMA minute between puffs OR as ordered by physician followed the manufacurer's guidelines, as OR according to manufacturer's the facilty policy instructed. recommendations." It is the facility's position that no deficient

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TATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			OMB NO. 0938-0391
	IDENTIFICATION NUMBER:	l` í	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	B. WING		07/16/2015
NAME OF PROVIDER OR SUPPLIE	R	1	STREET ADDRESS, CITY, STATE, ZIP C	•
AUBURN MANOR			501 OAK STREET	
1			CHASKA, MN 55318	
PREFIX (EACH DEF	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 425 Continued From	page 9	F	425	
			 practice occurred at F 425 exercising it's right to reque Dispute Resolution (IDR) re Unfortunately, that process required time frame allowe acceptable plan of corrective though the facility's position was not a deficient practice a result, the following plan implemented while the faci results of the IDR. Facility Wide Response Ad Residents With the Potenti Affected: 1. Trained medication aide an education refresher on administration with an emp inhaled medication administ task of medication administ monitor the ongoing daily f medication administration I medication aides. 3. Ongoing: Quarterly rand audits of medication administ trained medication administ the facility's quality assurant 	est an Informal eview. a exceeds the d for an on, even in is that there e at F 425. As has been lity awaits the dressing Other al to be es will receive medication thasis on orally stration. esponsible for ted nursing tration will unctions of by the trained dom sample istration by ill be conducted isultant. The become part of
			Data obtained from the qua process will be reviewed, v recommendations for inter- during the quarterly quality meetings for not less than	vith vention made, assurance

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	MENT OF HEALTH AN	ID HUMAN SERVICES					FORM): 11/16/2015 1 APPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE	
		245604	B. WING				07/	16/2015
NAME OF P	ROVIDER OR SUPPLIER		•		TREET ADDRESS, CITY, STATE, ZIP CODE			
AUBURN	MANOR				01 OAK STREET SHASKA, MN 55318			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	HOULD BE		(X5) COMPLETION DATE
F 441 SS=E		CONTROL, PREVENT	F	441				8/25/15
	safe, sanitary and cor to help prevent the de of disease and infection (a) Infection Control F The facility must estal Program under which (1) Investigates, contrining the facility; (2) Decides what process should be applied to a (3) Maintains a record actions related to infection determines that a resist prevent the spread of isolate the resident. (2) The facility must p communicable diseases from direct contact will trans (3) The facility must p communicable diseases from direct contact will trans (3) The facility must p communicable diseases from direct contact will trans (3) The facility must p hands after each direct hand washing is indice professional practice. (c) Linens Personnel must hand	pram designed to provide a mfortable environment and evelopment and transmission on. Program blish an Infection Control it - rols, and prevents infections cedures, such as isolation, an individual resident; and d of incidents and corrective ctions. d of Infection n Control Program ident needs isolation to infection, the facility must rohibit employees with a se or infected skin lesions th residents or their food, if ismit the disease. equire staff to wash their ct resident contact for which ated by accepted						

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		MEDICAID SERVICES			OMB NO. 0938-03 (X3) DATE SURVEY			
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				
		245604	B. WING		07/16/2015			
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
AUBURN MANOR				501 OAK STREET CHASKA, MN 55318				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ON (X5)			
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRC DEFICIENCY)	_D BE COMPLETIO			
F 441	Continued From page	e 11	F 44	1				
		is not met as evidenced						
	Based on observatio	n, interview and document		Auburn Manor has established and				
		ed to ensure resident		maintains an Infection Control Prog				
		and stored properly and		designed to provide a safe, sanitary				
	gloves were disposed			comfortable environment and to hele prevent the development and	p			
	infection control. In a	R48, R63) reviewed for		transmission of disease and infection	n an			
		linens and use appropriate			л.			
		oving technique for 1 of 1		The survey team cited that the facil	itv did			
		ved during catheter care.		not meet the requirement of ensurin	-			
		J. J		all resident equipment was clean ar	•			
	Findings include:		·	stored properly and gloves were dis				
				of properly for four residents. In add	lition,			
	-	observations on 7/13/15, at		the survey team cited that in one ca				
		node was located in the		one nursing assistant did not handle				
	resident's room/living			soiled linens properly or use approp				
		an. R63's bed pan was also bathroom floor at the time of		hand washing and gloving techniqu providing urinary catheter care.	e while			
	the initial observation			providing unitary catheter care.				
		ions on 7/14/15 and 7/15/15.		Immediate remedial measures inclu	Ided			
	· ·	.m. R16 was sitting in a		'In Time' training on infection control				
		er bag positioned on the		principles, including urinary cathete				
	floor. On 7/13/15, at 4	1:30 p.m. Subsequent		for the staff involved. All bedpans a	and			
		and 7/16/15 revealed the		urinals were immediately placed in				
		or R48's catheter was		appropriate coverings and stored a				
	stored on the bathroo inches from the reside toothpaste.	m vanity, approximately 12 ent's toothbrush and		from clean supplies in all resident re	ooms.			
	-			Facility Wide Response Addressing	Other			
	In addition R11's toile			Residents With the Potential to be				
	-	I on top of the bathroom sink		Affected:				
		m. The toilet cover was						
		e used gloves left on the floor		1. Facility direct care staff will rece				
	in the bathroom.			educational infection control refresh				
	When interviewed on	7/16/15, at 11:45 a.m. the		which will include proper storage of resident equipment, appropriate glo				
		e stated all staff had been		disposal, handling of soiled linens,				
	trained on use of star			catheter care, and any other infection				

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING ___ 245604 B. WING 07/16/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **501 OAK STREET** AUBURN MANOR CHASKA, MN 55318 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 441 Continued From page 12 F 441 infection control. She stated they had policies and control-related areas of concern. procedures on how to store and clean resident equipment, as well as for hand washing and 2. Gelled alcohol dispensers are available glove usage. She was unaware of the situations in each resident room and is used as an described observed as above. adjunct to hand washing when necessary. The appropriate use of gelled alcohol An undated Auburn Manor Home & Room order products will also be discussed at the policy noted directed staff to store "no toileting infection control training sessions. objects should be placed/visual throughout the room and not to store anything on the floor." An 3. Day-to-day compliance with standard undated Catheter Care policy specified staff infection control principles will be should "never let the bag touch the floor." A 6/15, monitored and enforced by the licensed Infection Control Program indicated the goal was nursing staff. to maintain compliance with state and federal regulations relating to infection prevention and 4. Ongoing: Quarterly random sample reporting. The comprehensive infection control audits of the proper cleaning and storage program addressed surveillance, prevention, and of residents' equipment will be conducted control of infections among residents and as part of the Resident and Room Safety audit process. Data obtained from the personnel. Findings include: quality assurance process will be reviewed, with recommendations for R31 was assisted with catheter cares on 7/16/15 intervention made, during the quarterly at 9:54 a.m. A nursing assistant, (NA)-C quality assurance meetings for not less explained the procedure, gathered supplies and than one year. 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

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DEPARTMENT OF HEALTH AND HUMAN SERVICES.

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PREFIX (EACH DEFICIEN	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245604 TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	A. BUILDING	E CONSTRUCTION STREET ADDRESS, CITY, STATE, ZIP CODE 501 OAK STREET CHASKA, MN 55318		SURVEY LETED	
XUBURN MANOR (X4) ID SUMMARY S PREFIX (EACH DEFICIEN TAG REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID	501 OAK STREET	07/	16/2015	
XUBURN MANOR (X4) ID SUMMARY S PREFIX (EACH DEFICIEN TAG REGULATORY OR	CY MUST BE PRECEDED BY FULL	ID 5	501 OAK STREET			
(X4) ID SUMMARY S PREFIX (EACH DEFICIEN TAG REGULATORY OR	CY MUST BE PRECEDED BY FULL	ID				
TAG REGULATORY OR	CY MUST BE PRECEDED BY FULL					
E 441 Continued From page		PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			
 placed on the bedsic and began pericare. prior to starting the p When the task was f soiled wash cloth on removed the incontin cream with a disposi- incontinence pad be then removed her so She again donned g hands, took a fresh v and assisted R31 to upper body. Na-C p drawers to pick out of intact. After R31 was mouthpiece from the hands to ask for ass her recliner. When f NA-C to transfer R3 use of a lift. After R3 NA-E placed the pilk catheter on the floor and left the room. NA-C took the dirty v plastic bag, emptied gloves When task was com clumsy and didn't wa explained she knew wash cloth on the be 	de table. She donned gloves She did not wash per hands procedure. inished, she placed the the bedside table and nent pad, applied barrier able cloth and placed a clean neath R31. She removed	F 441				

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	MENT OF HEALTH AN		-				FORM /	11/16/2015 APPROVED 0938-0391
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		. ,	PLE CONSTRUCTION		(X3) DATE SI COMPLE	
		245604		B. WING		_	07/10	6/2015
NAME OF PF	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, S	TATE, ZIP CODE		
AUBURN					501 OAK STREET			
AUDURNI	MANOR				CHASKA, MN 55318			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM,	FULL	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 441	Continued From page catheter was placed w hospital on 5/24/15 af was noted 6/3/15. A nursing note dated for an antibiotic (Cipro R31 's diagnosis liste dated 6/16/15 include infection, infection due catheter, urine retented disease. The care plan dated 6 monitor for signs and infection (UTI) prn, as toileting and to provide policy. During an interview or director of nursing (DO staff would not place a pericare on a bedside hands before and after she was unclear if if s their hands before and proceeding from a dirf "There has been new need to see what our the facility's policy and handwashing, gloving care, the DON explair wash their hands before when going from a dirf	when admitted to the ter a fall. A urinary in 7/14/15, noted the co analysis' 7/15/15 noted new o b) for R31. d on careher care pl d: history of urinary e to indwelling urine on and chronic kidne 6/16/15 directs staff to symptoms of urinary sist with pericare and e catheter cares per n 7/16/15, at 10:42 a DN) stated she expe a washcloth used for table and for staff to er a procedure. Howe taff was expected to d after gloving or which ty to clean procedure training on this and policy says." After re d procedures regardi , pericare and catheir ned she did expect si ore and after gloving ty to clean procedure training on this and policy says." After re d procedures regardi ned she did expect si ore and after gloving ty to clean procedure	ollection rders an y b tract d house .m. the cted e wash ever, wash en e, l will view of ng ter taff to and e.	F 44				
FORM CMS-256	7(02-99) Previous Versions Obs	olete	Event ID: WSUP11		Facility ID: 00335	If continua	ation sheet F	Page 15 of 16

		ID HUMAN SERVICES MEDICAID SERVICES			(APPROVED 0.0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		245604	B. WING			07/	16/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	E, ZIP CODE		
				CHASKA, MN 55318			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTI) CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 441	performed by all staff catheter care, includin such as catheters on bedside table. She a their hands before an explained staff is train these areas The Auburn Manor Ca undated, directs staff gloves before coming incontinent pad, and/a disposing of soiled lin appropriately. Wash The Auburn Manor in Pertinent Perineum c from clean to dirty, ne wash hands and appl	ntrol precautions were during pericare and ng not placing equipment the floor or dirty linen on lso expected staff to wash d after using gloves. She ned on an on-going basis in atheter Care/Perineal Care, sanitize hands and don in contact with linen, or resident. Finish by ten/product/equipment hands. service guidelines for are, undated directs staff go ever from dirty to clean, y gloves before to care the staff is directed to	F 4	41			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 00335

If continuation sheet Page 16 of 16

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245604	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 9/8/2015
Name	of Facility		Street Address, City, State, Zip Code	
AU	BURN 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	i) Date	(Y4) Item	(Y5)	Date	(Y4) Item	(Y5)	Date
		Correction Completed			Correction Completed			Correction Completed
ID Prefix	F0246	09/08/2015	ID Prefix	F0371	09/08/2015	ID Prefix	F0425	09/08/2015
	483.15(e)(1)	_		483.35(i)	-	•	483.60(a),(b)	
LSC		-	LSC			LSC		
		Correction			Correction			Correction
		Completed			Completed			Completed
ID Prefix	F0441	09/08/2015	ID Prefix		-	ID Prefix		
0	483.65	_	Reg. #			Reg. #		
LSC		_	LSC			LSC		
		Correction			Correction			Correction
		Completed			Completed			Completed
ID Prefix		_	ID Prefix			ID Prefix		
Reg. #		_	Reg. #			Reg. #		
LSC		_	LSC			LSC		
		Correction			Correction			Correction
		Completed			Completed			Completed
ID Prefix		_	ID Prefix		-	ID Prefix		
Reg. #		_	Reg. #		-	Reg. #		
LSC		_	LSC					
		Correction			Correction			Correction
		Completed			Completed			Completed
ID Prefix		_			-			
Reg. # LSC		_	Reg. # LSC		-	Reg. #		
		_						
Reviewed By	Reviewed	Ву	Date:	Signature of Surve	eyor:		Dat	e:
State Agenc	, GD/mr	n	11/16/20	15	3092	3	09	9/08/2015
Reviewed By	Reviewed	Ву	Date:	Signature of Surve	yor:		Date	e:
CMS RO								
Followup to	Survey Completed on:			-		eficiencies. Was	•	
	7/16/2015			Uncorrecte	a Deficiencies	(CMS-2567) Sent	to the Facility? YE	IS NO

DEPARTMENT OF HEALTH						DICARE & MEDICAID SERVICES
					AND TRANSMITTAL	ID: WSUP
					TE SURVEY AGENCY	Facility ID: 00335
1. MEDICARE/MEDICAID PROVIDER (L1) 245604	R NO.	3. NAME AND AI (L3) AUBURN M		CILITY		4. TYPE OF ACTION: $2(L8)$
2.STATE VENDOR OR MEDICAID NO).	(L4) 501 OAK ST	FREET			1. Initial2. Recertification3. Termination4. CHOW
(L2) 422243100		(L5) CHASKA, M	/IN		(L6) 55318	5. Validation 6. Complaint
5. EFFECTIVE DATE CHANGE OF O	WNERSHIP	7. PROVIDER/SU	JPPLIER CATEC	FORY	<u>02</u> (L7)	7. On-Site Visit 9. Other
(L9)		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	8. Full Survey After Complaint
6. DATE OF SURVEY 07/16/2	2015 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	FISCAL YEAR ENDING DATE: (L35)
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/III		12/31
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/31
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED	AS:		
From (a):		A. In Complia	nce With		And/Or Approved Waivers Of	The Following Requirements:
To (b):			equirements e Based On:		2. Technical Personnel	=
12.Total Facility Beds	61 (L18)	-	cceptable POC		3. 24 Hour RN 4. 7-Day RN (Rural SN	7. Medical Director 8. Patient Room Size
·	·- 、 ,		1		5. Life Safety Code	9. Beds/Room
13.Total Certified Beds	61 (L17)	X B. Not in Con Requirem	npliance with Prog ents and/or Appli		* Code: B *	(L12)
14. LTC CERTIFIED BED BREAKDOW	/N				15. FACILITY MEETS	
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
61						
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REMA	RKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):		
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Mam Danage LIEE NE	тт	C	08/24/2015		Mark meath	, Enforcement Specialist
<u>Mary Bruess, HFE NE</u>	11			(L19)		09/10/2015 (L20)
PAR	T II - TO BE	COMPLETED I	BY HCFA RI	EGIONAI	L OFFICE OR SINGLE S	TATE AGENCY
19. DETERMINATION OF ELIGIBILIT	ГҮ		IPLIANCE WITH	H CIVIL		ncial Solvency (HCFA-2572)
1. Facility is Eligible to Par	rticipate	KIGI	HTS ACT:		 3. Both of the Above 	ol Interest Disclosure Stmt (HCFA-1513)
2. Facility is not Eligible	(L21)					
	(121)					
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION	BEGINNING	J DATE	ENDING DA	ТЕ	VOLUNTARY 00	
08/01/1992					01-Merger, Closure 02-Dissatisfaction W/ Reimburse	05-Fail to Meet Health/Safety ement 06-Fail to Meet Agreement
(L24)	(L41)		(L25)		03-Risk of Involuntary Terminatio	m
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change
	A. Suspension	i of Admissions.	(L44)			00-Active
(L27)	B. Rescind S	spension Date:				
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY	CARRIER NO.		30. REMARKS	
		03001				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	20	. DETERMINATION		DATE		
51. KO KECEIF I OF CMIS-1339	32	. DETERMINATION	OF AFFRUVAL	DALE		
	(L32)			(L33)	DETERMINATION APPI	ROVAL



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;

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

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

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

DEPARTMENT CONTACT

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

Gayle Lantto, Unit Supervisor 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. Auburn Manor July 27, 2015 Page 4

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 Auburn Manor July 27, 2015 Page 5

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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 Auburn Manor July 27, 2015 Page 6

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

	-	AND HUMAN SERVICES			APPROVED
CENTERS I	FOR MEDICARE	& MEDICAID SERVICES		OMB NO	0938-0391
STATEMENT OF AND PLAN OF CO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	()		E SURVEY IPLETED
		245604	B. WING _		16/2015
NAME OF PROV	VIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
AUBURN MA	NOR			501 OAK STREET CHASKA, MN 55318	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000 IN	ITIAL COMMENT	S	F 00		
as De en at for	your allegation o partment's accept rolled in ePOC, y the bottom of the m. Your electron	f correction (POC) will serve f compliance upon the otance. Because you are our signature is not required first page of the CMS-2567 ic submission of the POC will ion of compliance.			
on va rec you F 221 48	-site revisit of you lidate that substa gulations has bee ur verification.	acceptable electronic POC, an ir facility may be conducted to ntial compliance with the in attained in accordance with O BE FREE FROM AINTS	F 22	21	8/25/15
ph dis	ysical restraints in scipline or conven	e right to be free from any nposed for purposes of ience, and not required to medical symptoms.			
by Ba rev as: de a p R2 Fir R3 roo he	: ased on observat view, the facility fa sessment to dete fined perimeter m botential restraint 23) reviewed for p ndings include: 88 was observed so om on 7/14/15, at r call light was wit	IT is not met as evidenced ion, interview and document ailed to conduct an rmine the appropriate use of a nattress (with raised edges) as for 2 of 5 residents (R38, otential restraint use. seated in a recliner in her 9:36 p.m. R38's feet were up, thin reach, and a wheeled er reach and nearby the bed.		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	
LABORATORY DIR	ECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE	(X6) DATE

Electronically Signed

08/06/2015

PRINTED: 08/24/2015

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.

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245604 **B** WING 07/16/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **501 OAK STREET AUBURN MANOR** CHASKA, MN 55318 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 221 Continued From page 1 F 221 The bed had a defined perimeter mattress. On Correction is not an admission that 7/16/15, at 8:38 a.m. R38 was observed lying in adeficiency exists or that one was cited bed on her back. She was lying on her left side correctly. We wish to preserve our right to and her left leg was hanging over the edge of the dispute these findings in their entirety should any remedies be imposed. mattress. R38's MDS dated 5/8/15, indicated R38 was Residents of Auburn Manor have the right unsteady, was only able to stabilize self with staff to be free from any physical restraints imposed for purposes of discipline or assistance when moving from seated to standing position, walking, turning around, moving on and convenience, and not required to treat the off the toilet, and surface to surface transfers. resident's medical symptoms. It is the position of Auburn Manor that physical R38's current NA care sheet carried by the NAs to restraints are not used on any of its outline resident care needs indicated R38 had a residents. history of falls with hip fracture. Although not part of the deficiency statement at F 221, it is important to note On 7/15/15, various staff were interviewed. At that Resident #38 was assessed for 5:22 p.m. NA-I reported R38 was able to get herself out of the recliner, and "if she wanted to" independent use of her recliner on she could get out of bed herself. NA-I also stated 3/17/15. The aforementioned R38 was supposed to, however, use assistance assessment is included in Appendix A of from one staff person. this document. NA-G was interviewed at 7:51 p.m. NA-G explained that R38 had "a hard time getting out of Resident #23 has been assessed for the bed because of the mattress...she tries to get use of a recliner also. A copy of that out," but the most she could do was sit on the assessment which supports his ability to side of the bed. NA-G said R38 needs a "boost independently use the recliner with no up," and that the resident had not fallen recently. restriction of his movement can be found in Appendix C. The resident is able to use A trained medication aide (TMA)-A then stated at the electronic control, but demonstrates 8:07 a.m. that R38 needed limited assistance poor judgment. The resident's wife was from one staff, and "just needed a boost up...she involved in the decision to allow the can get out of the chair herself. It's not that she resident to have full control of the remote can't, it's just harder for her." TMA-A also stated which operates the chair. The recliner R38 could not get out of bed by herself and if R38 has been determined not to impose upon wanted help she would yell and call out, and she his freedom of movement or normal would forget to use her call light. access to his body.

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 00335

If continuation sheet Page 2 of 21

PRINTED: 08/24/2015

ATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MUL	TIPL			0938-039 SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:					LETED
		245604	B. WING			07/1	6/2015
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
UBURN	MANOR				D1 OAK STREET HASKA, MN 55318		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE
F 221	Continued From pa	age 2	F 2	21			
		stated R38 could get out of					
		erself, but was "not supposed			Although a designated form encapsu		
	to," and was to do	so only with help from staff.			all of the ongoing assessment activiti both residents in this example may n		
	On 7/15/15. at 8:23	a.m. RN-C verified there was			found in either medical record, it is		
	no assessment der	monstrating the perimeter			important to note that multiple		
		ner were not a potential			assessments supporting the use of the	he	
		IN-C also stated the RN's			perimeter mattresses and recliners	auct	
	completed restrain	l assessments.			existed. The critical thinking nurse m be able to analyze all data collected	lusi	
	At 8:39 a.m. NA-F	stated R38 required staff			regarding mobility status as supporte	ed by	
		sferring. NA-F stated she was			Section G of the MDS, fall history,		
	sure R38 could get supposed to do so.	t out of bed herself but was not			physical and occupational therapy assessments, and quality of life outco	omos	
	supposed to do so.				(including freedom of injury from falls		
		at 8:41 a.m that usually a nurse			of bed) when determining whether ar	ny	
		npleted restraint assessments.			device has the effect of restraining th		
		e was no assessment and stated, "No, we not do			resident. Professional assessments the nurse as well as the entire clinica		
		ents for bolster [perimeter]			team are ongoing and reflected in	11	
		ive not done them in the past			progress notes and throughout the		
		been asked to do restraint			resident's medical record. All of the		
		olster mattresses." RN-D			gathered resident assessment data,		
		ter mattress was applied and blan on 10/14/14, because of a			is fluid in nature and not just based u one specific assessment completed a		
	fall on 10/13/14.				given point in time, much like the one		
					survey team referenced in their exam		
		served with a defined perimeter			is used daily to determine appropriate		
		5, at 6:30 p.m. A recliner was om. The following day at 3:10			adaptive resident devices usage and prevention of restricting resident	ine	
		erved sitting in a recliner with			movement or access to their bodies		
		e call light on arm of chair, and			(physical restraints.) No where in the		
	a mat on the floor i	n front of his feet.			interpretive guidelines at F 221 does	ıt	
	On 7/14/15, at 9:43	3 a.m. NA-H reported R23			dictate that a specific, one page, assessment form be present in the		
	needed staff assist	ance to get out of bed, and			resident's medical record to support	the	
		get out of bed independently.	1		use of a perimeter mattress or to ide		
	TIZS Was unable to	get out of bed independently.			possible physical restraints.	intity	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245604 **B** WING 07/16/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **501 OAK STREET AUBURN MANOR** CHASKA, MN 55318 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PRÉFIX** (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 221 Continued From page 3 F 221 transferred with an EZ Stand and one staff assist from staff, and alarms were utilized on R23's Based upon this misrepresentation, and chair and bed. NA-G stated R23 had not the information shared above, the facility's transferred himself "again" and that she thought position is that no deficient practice R23 had become "scared after his last fall" when occurred at F 221 and the facility will he self-transferred with a family member. exercise it's right to initiate the Informal Dispute Resolution (IDR) process. Unfortunately, that process exceeds the At 8:58 a.m. NA-F then stated R23 had not required time frame allowed for an self-transferred again, as he now has "gotten all the bells and whistles" (alarms). acceptable plan of correction, even though the facility's position is that there At 10:38 a.m. NA-G stated R23 could not transfer was not a deficient practice at F 221. As himself out of bed, and does not even try to do a result, the following plan has been so. NA-G also stated R23 once put his recliner implemented while the facility awaits the chair up high and was "kind of standing but then results of the IDR review. the mat on the floor has alarms." NA-G further Facility Wide Response Addressing Other stated she did not know when the perimeter Residents With the Potential to be mattress was put on R23's bed. Affected: R23's MDS dated 4/10/15, indicated the resident was unsteady, was only able to stabilize with staff 1. The facility has adopted a Device assistance when moving from seated to standing Decision Guide published by Primaris (Appendix D1) as an additional position, walking, turning, moving on and off toilet, and surface to surface transfers. assessment tool which compliments what the facility already has un place. The R23's care plan indicated he was at risk for guide and protocol will be utilized falling, as well as a history of falls and whenever the IDT contemplates initiating self-transfers. The goal was for R23 to remain a resident adaptive device to ensure that free of injury from falling. the device does not meet the criteria of a physical restraint both before its implementation and on an ongoing basis Progress notes revealed R23 experienced an unwitnessed fall on 1/24/15, at 10:10 p.m. The or if the resident's status changes. An resident was found in his room, crawling out of example of that tool accompanies this document under Appendix E. Facility bed. The resident was found kneeling on the sensor mat, which was alarming. licensed nursing staff will be educated on the tool at the next licensed nursing staff meeting on August 24, 2015. 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 2. Both residents in the example will be

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245604 **B** WING 07/16/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **501 OAK STREET AUBURN MANOR** CHASKA, MN 55318 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PRÉFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 221 Continued From page 4 F 221 perimeter mattress and the recliner were not assessed using the above guide and potentially restraints for R23. protocol. On 7/16/15, at 8:48 a.m. RN-C reported, "We do 3. Ongoing: Quarterly random sample not do restraint assessments here for bolster audits of residents with adaptive mattresses." equipment will occur for not less than one year from date certain. The focus of these audits will be to validate that the The DON then stated at 9:22 a.m. "We have not thought of bolster mattresses as a potential required assessments and documentation restraint. We have put the mattresses in as fall exist in the resident's medical record to interventions." support the use of the adaptive equipment and to ensure that the equipment is not The administrator reported in an interview at 1:33 functioning as a physical restraint. Data p.m. when asked about restraints, "If it does not obtained from the quality assurance process will be reviewed, with meet a physical restraint definition, we do not treat it as a restraint." The administrator also recommendations for intervention made. stated, "Often times it is based on the residents' during the quarterly quality assurance mobility, their ability to use devices or a history of meetings for not less than one year. 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.

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		AND HUMAN SERVICES & MEDICAID SERVICES		F	NTED: 08/24/2015 ORM APPROVED 3 NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			3) DATE SURVEY COMPLETED
		245604	B. WING		07/16/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
AUBURN	MANOR			501 OAK STREET CHASKA, MN 55318	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 221 F 246 SS=D	to treat specific mee emergency situation from eminent dange defined as any man mechanical device, attached or adjacen the individual canno restricts freedom of access to one's boo 483.15(e)(1) REAS OF NEEDS/PREFE A resident has the r services in the facili accommodations of preferences, excep	cal restraints will be used only dical symptoms or in an n to protect residents or others er'Physical Restraints' are nual method or physical or material or equipment nt to the resident's body that ot remove easily, which movement or restricts normal dy" ONABLE ACCOMMODATION ERENCES	F 22		8/25/15
	by: Based on observat review the facility fa within reach for 1 of for environmental c Findings include: On 7/13/15, at 2:45 on her back with the slightly, watching a next to her on the b locate with verbal c	NT is not met as evidenced ion, interview and document iled to ensure a call light was f 2 (R21) residents reviewed oncerns. p.m. R21 was observed lying e head of the bed raised television. Her call light was ed, which she was able to ues from the surveyor. at 7:14 p.m. R21 was in her		Auburn Manor respects each residen right to reside and receive services in facility with reasonable accommodation 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 we they Observed R21's call light to be or floor and out of reach of the resident. resident is known to become restless will throw her call light on the floor at times. Contributing factors to this find	the ons le vhen n the This and

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245604 **B** WING 07/16/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **501 OAK STREET AUBURN MANOR** CHASKA, MN 55318 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 246 Continued From page 6 F 246 room sitting in her wheelchair next to her bed. includes the call light's cord clip failing The doors to her room were open, and the from, what more than likely was, the force resident could be visualized from the hallway. of the resident's pulling on the cord and She was dressed in a T-shirt and incontinence throwing it. This was an isolated event supported by the number of other times brief and her bare legs were out in front of her on the chair leg rest. She was reaching toward the the surveyor described the call light being bed with her left hand. The call light was out of within the resident's reach as noted in the the resident's reach on the floor behind the example. This event was incidental in wheelchair. At 7:17 p.m. a nursing assistant (NA) nature and not a result of a failed practice came into the room and asked R21 what she or facility system. Residents' call lights could do to help. Without picking up the call light, being within reach is the standard of care the NA hurriedly left R21's room stating, "I'll be at Auburn Manor and all staff understand right back." At 7:20 p.m. the NA came down the the importance and necessity of this. hall with a second NA, but instead of returning to R21's room, the two NAs went into the adjacent The call light cord clip was replaced resident room. immediately upon its discovery and had been noted to be functioning properly At 7:28 p.m. the surveyor asked a registered during the remainder of the survey, again nurse (RN)-A to observe the location of R21's call as noted throughout the surveyor's light. RN-A picked up the light and verified it example. should not have been left on the floor out of R21's reach. She explained, "She is fidgety and she Facility Wide Response Addressing Other probably threw it off her. They [NAs] should have Residents With the Potential to be pinned it on her chair," which RN-A then did. Affected: RN-A said R21 probably could not have used the call light effectively, and added she was normally, 1. Facility staff will be provided a reminder "under staff eyes when up in the wheelchair of the necessity to ensure that resident's during the day." RN-A said R21 was admitted call lights are always within the resident's after a fall with hip fracture, and had experienced reach. This will be accomplished using one fall at the facility. the facility's electronic learning system. R21 had been newly admitted to the facility from 2. Charge nursing personnel will be the hospital. The initial Minimum Data Set responsible for ongoing compliance of call lights being within reach by doing visual revealed the resident had been experiencing delirium symptoms (an acute abnormal mental monitoring of resident room's for state often associated with infection) with appropriate call light placement. fluctuating cognition. 3. Ongoing: Quarterly random sample On 7/15/15, at 9:52 a.m. NA-F stated R21 was audits of correct call light placement will

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	OF DEFICIENCIES	& MEDICAID SERVICES		LE CONSTRUCTION		. 0938-039 E SURVEY	
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:				IPLETED	
		245604	B. WING		07	/16/2015	
NAME OF	PROVIDER OR SUPPLIER		Ş	STREET ADDRESS, CITY, STATE, ZIP CODE			
AUBURI	MANOR		501 OAK STREET CHASKA, MN 55318				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIC DATE	
F 246 F 371 SS=F	able to use her call NA-F also stated in 'call light happy.'" N was out of her room the bed and when I clipped the call ligh interview R21's call onto the bed sheet On 7/15/15, at 11:3 (DON) was intervie residents who were would have been o can see themstaf if they have any ner- bed during the day expect that to show to be in the policy. She would need to spea maintenance, "beca technical side." Sin of director of nursin had not performed also stated she exp policies. In addition be placed in reach use them. When as plans to indicate wh the call light she reach 483.35(i) FOOD PF STORE/PREPARE The facility must -	light and did use her call light. I fact, "Sometimes she gets IA-F further stated when R21 n, the call light was clipped to R21 sat in her recliner, staff t to the recliner. At time of light was observed clipped at the head of R21's bed. 5 a.m. the director of nursing wed. She explained that a unable to use their call lights ut of their rooms "where staff if should round on them to see eds during the night, or naps in time." She added, "I would v in the care plan. It's not likely Specific rounding times should "When asked whether call en performed she said she ak to the director of ause he does more of the ce she took over the position ng 5/18/15, DON stated she any call light audits. The DON bected staff to follow facility n, she expected call lights to of residents who were able to sked if she would expect care nether a resident could not use sponded, "No, I have not had causemy thought is that they n."	F 246	be conducted utilizing the facility's Resident and Room Safety Audit (Appendix E). Data obtained fro quality assurance process will be reviewed, with recommendations intervention made, during the qua quality assurance meetings for no than one year.	Tool m the for arterly	8/25/15	

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG	CON	IPLETED
		245604	B. WING _		07/	/16/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
AUBURI	MANOR			501 OAK STREET CHASKA, MN 55318		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
F 371	authorities; and	tory by Federal, State or local distribute and serve food	F 37	'1		
	by: Based on observative review, the facility free source that sanitative dishwashing process dishwasher temper failed to ensure that were kept clean and This had the potent that resided in the free findings include: On 7/14/15, at 9:56 the kitchen, a dietate running dishes throw tank temperature we Fahrenheit (F), the degrees F and the findings of plates throw and the temperature above. At the same sent through the dist them for use. The same sent through the dist them for use. The same sent throot and the temperature sent through the dist them for use. The same sent throot and the same sent through the dist them for use. The same sent through the dist them for use. The same sent through the dist them for use. The same sent through the dist them for use. The same sent through the dist them for use. The same sent through the dist them for use. The same sent through the dist them for use. The same sent through the dist them for use. The same sent through the dist them for use. The same sent through the dist them for use. The same sent through the dist them for use. The same sent through the dist them for use. The same sent through the dist them for use. The same sent through the dist them for use. The same sent through the dist them for use. The same sent through the dist them for use. The same sent through the dist them for use. The same sent through the dist them for use.	a.m. during a follow-up tour of ry aide (DA)-A was observed ugh the dishwasher. The wash vas noted to be 132 degrees rinse tank temperature at 142 final rinse temperature was -A ran about four additional ugh the dishwasher machine es remained the same as time, DA-B was taking dishes sh machine and began storing surveyor intervened and asked dishwasher temperature		Auburn Manor does procure fo sources approved or considered satisfactory by Federal, State and authorities and stores, prepares distributes that food under sanit conditions. On 7/14/15, the survey team not the dishwasher in the kitchen w heating to required temperature facility's dietary manager was c and determined that the dishwa booster heater had been turned Contributing factors to this findin included a new dietary staff me being involved in the finding. T aid stated that she was nervous survey process and forgot to tur booster heater. Once the boos was turned on and the water temperatures reached required dishes that would have been af the water temperatures not read required levels were re-washed proper temperatures. This was	d nd local s and arry ted that as not es. The onsulted sher l off. ng mber he dietary s with the rn on the ter heater levels, all fected by ching at the	

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPL.	E CONSTRUCTION	MB NO. (X3) DATE	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:					PLETED
		245604	B. WING _			07 /1	6/2015
NAME OF I	PROVIDER OR SUPPLIER	-		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AUBURN	MANOR				01 OAK STREET CHASKA, MN 55318		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIC DATE
F 371	Continued From pa	ae 9	F 3	71			
		rvation, DA-A stated that she			In response to the above findings, t	the	
		er temperatures to be between			dietary manager is personally traini		
		nd the final rinse temperatures			each new dietary team member on		
		grees. DA-A reported she had			on the booster heater and making s		
		ratures "this morning before nachine was working okay."			is on for each shift. In addition, the manager has re-trained her staff or		
		nachine was working okay.			checking dishwasher temperatures		
	On 7/14/15, at 10:1	1 a.m. the dietary manager			shift and report irregularities to the		
	(DM) verified that th	ne dishwasher temperatures			manager immediately. In addition,		
		F for the wash cycle and 132			dietary manager monitors the temp	erature	
		nal rinse. DM stated that "the			logs for completion daily.		
		if." The DM then checked on rified that it had been turned			During the initial tour of the kitchen	on	
		booster on and asked DA-A to			7/13/15 at 12:59 p.m., the outside	, 011	
	run empty trays thro	ough the dishwasher machine.			environmental temperature was in		
		empty trays, the wash			mid-ninety degrees Faherenheit wit		
		ecorded at 152 degrees F and			dew point of 72 degrees Faherenhe		
		0 degrees F. The surveyor dishes previously washed be			The facility's roof-top air conditionin was being replaced that day resulting		
	re-washed at the pr				the kitchen being warmer and more	e humid	
					that normal conditions. This was a		
	,	hine temperature log was			isolated event of over 20 years, sin		
		5, at 1:13 p.m. The log			unit was the original cooling unit for		
		res were supposed to have e times daily at breakfast,			part of the building. The administration toured the walk-in freezer after beir		
		ata was unrecorded for three			summoned by the dietary manager		
		four days for lunch and seven			regarding the surveyor's concern.		
	days for dinner betw	ween 7/1 and 7/13/15. The DM			was some mild frosting of on the ba	ase of	
		stencies in monitoring of the			one fan guard. The area measured		
	dishwasher temper	atures.			inches with no thickness. There wa		
	During a follow-up i	nterview on 7/15/15, at 12:57			ice build-up and no ice was blowing the contained food boxes. The frost		
		ed all dietary employees had			the thermometer disseminated by s		
	been trained on usi	ng dishwasher and how to log			placing a finger on the face of the		
		e expectations were that			thermometer. The finding was remo		
		e temperatures be logged			later in the afternoon when the new		
	every shift and irreg	DM further explained that the			roof-top unit was operational. This was an isolated event which was	maing	
		sed to have been turned on in			unavoidable upon analysis of causa		

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM APPROVE OMB NO. 0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	- (X3) DATE SURVEY COMPLETED
		245604	B. WING		- 07/16/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	
AUBURI	N MANOR			501 OAK STREET CHASKA, MN 55318	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION (X5) /E ACTION SHOULD BE COMPLETIO D TO THE APPROPRIATE CIENCY)
F 371	dishwasher, and the night. During an interview director of maintena temperatures was s booster was turned maintenance said the required 180 degree rinse. The Hatco Corpora Heater's Installation 2013 directed that, heaterwhen the b sufficient heating tin and check the wate readings on the gau the booster outlet s (85-86 degrees Cer On 7/13/15, at 12:5 tour, the two fan gu food boxes in the ki covered with frost b blowing the ice all of verified the findings On 7/15/15, at 9:39 refrigerator by the m juice was spilled an from the bottom she small freezer on top covered with built-u findings were verifie (RN)-A at the time of	on 7/16/15, at 10:34 a.m. the ance stated the hot water set at 160 degrees. If the off, the director of he water would not heat to the es temperature for the final tion Electric Booster Water and Operation Manual dated "Turn on the booster water ooster water heater has had me, operate the rinse cycle or temperature and pressure uges. Water temperature at hould be 185-190 degrees F	F 3	 factors. The freezer/refrigerativity kitchenette area referente area referente	erenced in the orange juice spill and /15/15 was an isolated no immediate health bes have a ng Policy and eaks to cleaning the s needed routinely.' In the communal esulted from between nursing and s to the need for the ted. When this issue ity staff's attention, emoved the unit to onse Addressing Other Potential to be dietary manager's e to the lings, the dietary ue to personally train am member on turning er and making sure it In addition, the dietary ue to train her staff on er temperatures every gularities to her lition, the dietary ue to monitor the

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245604 **B** WING 07/16/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **501 OAK STREET AUBURN MANOR** CHASKA, MN 55318 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 371 Continued From page 11 F 371 responsibility" to make sure the refrigerator was Policy and Procedure has been updated kept clean. RN-A stated that she did not know to include the defrosting of the communal who was responsible for defrosting the freezer. kitchenette refrigerator at least every six months and as needed. The defrosting of During interview on 7/15/15, at 10:32 a.m. the the freezer has been added to the director of nursing (DON) stated that she did not automated electronic (TELS) know who was responsible for defrosting the maintenance preventative maintenance freezer, but said "I will check and let you know." schedule. The health unit coordinator will The DON stated her expectations were that staff be responsible for the day to day will cleaned the freezers and refrigerators as per monitoring for everyone's compliance with the schedule and as needed. The following day at the requirements of the sanitation of the 12:50 p.m. the DON stated that she did not have refrigerator/freezer. "anything written down" but the maintenance director usually defrosted the freezer every six 3. Ongoing: Quarterly random sample audits of dishwasher temperatures and months. the kitchenette refrigerator/freezer The undated Auburn Manor Refrigerator Cleaning sanitation will be conducted and Policy and Procedure indicated, "Refrigerators in incorporated into the facility's quality resident's rooms, kitchenette area, and med assurance program. Data obtained from [medication] room will be cleaned as needed the quality assurance process will be routinely to reduce the spread of infection." reviewed, with recommendations for intervention made, during the guarterly quality assurance meetings for not less than one year. F 425 F 425 483.60(a),(b) PHARMACEUTICAL SVC -8/25/15 ACCURATE PROCEDURES, RPH SS=D 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

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	08/24/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3) DAT	E SURVEY PLETED
		245604	B. WING			16/2015
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	ST	REET ADDRESS, CITY, STATE, ZIP CODE	
AUBURN	MANOR				01 OAK STREET HASKA, MN 55318	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	the needs of each r The facility must en a licensed pharmac	drugs and biologicals) to meet esident. nploy or obtain the services of sist who provides consultation e provision of pharmacy	F 4	25		
	by: Based on observat review, the facility fa medication from an manufacture's guid whose inhaler admit Findings include: R61's Symbicort inh administered on 7/1 medication assistar inhaler as required asked R61, "Are yo from the inhaler and TMA-A then shook waiting in between puff to R61 who the TMA-A had not inst prior to breathing in following the two pu minute between pur expand the airway a medication.	NT is not met as evidenced ion, interview and document ailed to properly administer inhaler according to elines for 1 of 1 resident (R61) nistration was observed. haler (for asthma) was 4/15, at 10:00 a.m. a trained at (TMA)-A. While shaking the prior to administration TMA-A u ready?" R61 took a puff d breathed in the medication. the inhaler, and without puffs, administered a second in breathed in the medication. ructed the resident to exhale either puff, to hold his breath uffs, and did not wait a full ffs to allow the medication to and provide full benefit of the vation TMA-A stated, "I think I hods before administering the			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	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245604 **B** WING 07/16/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **501 OAK STREET AUBURN MANOR** CHASKA, MN 55318 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 425 Continued From page 13 F 425 second puff...That's how I was showed to give it." permitted by State law, under the general supervision of a licensed nurse. On 7/14/15, at 10:12 a.m. a licensed practical nurse (LPN)-A was asked about R21's inhaler Resident #61 has a long-standing history medication. She reported, "I normally wait about of controlling his asthma with Symbicort. one minute before each puff of the inhaler. LPN-A He has been receiving the Symbicort also stated, "The TMAs usually give the inhaler since his admission last January. inhalers...I instruct the resident to breathe out Resident #61 is very familiar with the before breathing in the inhalation and hold breath inhaler administration protocol. He does for as long as they can." not require daily reminders of when to breathe in, when to hold his breath and At 10:14 a.m. director of nursing stated, "I would when to exhale as someone new to the expect TMAs to know how to give the inhaler by protocol or someone with a cognitive the packaging or from notes." impairment may. Those basic instructions are not appropriate or dignified for R61. His MDS scores in Section C would When asked for a policy regarding inhalers on 7/15/15, at 9:22 a.m. the director of nursing support his cognitive function and ability to stated she expected staff to follow manufacture's understand a consistent medication guidelines when administering inhalers. administration protocol without repeated elementary instructions of when to The undated Orally Inhaled Medications policy breathe in and when to breathe out. directed the staff to "Explain steps to resident: Resident #61's MDS Section C Have resident exhale fully--shake unit to disperse accompanies this document (Appendix F). medication--place mouthpiece in front of mouth or in mouth according to manufacturer's Upon further review of the manufacturer's recommendations--while inhaling slowly and instructions found at their website. deeply through mouth, depress medication https://www.mysymbicort.com/asthma/sy canister fully. Have resident hold breath for 10 mbicortinhaler/symbicort-inhaler.html, the seconds OR as long as possible OR according to only time required between puffs of manufacturer's recommendations. Have resident symbicort is the time required to re-shake exhale through pursed lips...Wait approximately 1 the inhaler, which the TMA did. The TMA minute between puffs OR as ordered by physician followed the manufacurer's guidelines, as OR according to manufacturer's the facilty policy instructed. recommendations." 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

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		AND HUMAN SERVICES			FORM	08/24/20 APPROVE 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY IPLETED
		245604	B. WING		07/	16/2015
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		
AUBURN	MANOR			501 OAK STREET		
		TEMENT OF DEFICIENCIES		CHASKA, MN 55318 PROVIDER'S PLAN OF COF	PRECTION	()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 425	Continued From pa	ige 14	F 42		for on	
				required time frame allowed acceptable plan of correction though the facility's position was not a deficient practice a result, the following plan h implemented while the facility results of the IDR.	n, even is that there at F 425. As as been	
				Facility Wide Response Add Residents With the Potentia Affected:		
				1. Trained medication aides an education refresher on m administration with an emph inhaled medication administ	nedication lasis on orally	
				2. Licensed nursing staff re the oversight of the delegate task of medication administr monitor the ongoing daily fu medication administration by medication aides.	ed nursing ration will nctions of	
				3. Ongoing: Quarterly rando audits of medication administ trained medication aides wil by the pharmacy nurse cons results of those audits will be the facility's quality assurand Data obtained from the qual process will be reviewed, wi recommendations for interve during the quarterly quality a meetings for not less than o	stration by I be conducted sultant. The ecome part of ce program. ity assurance th ention made, assurance	
F 441 SS=E	483.65 INFECTION SPREAD, LINENS	I CONTROL, PREVENT	F 44	-		8/25/15

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245604 B. WING 07/16/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **501 OAK STREET AUBURN MANOR** CHASKA, MN 55318 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 441 Continued From page 15 F 441 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:

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245604 **B** WING 07/16/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **501 OAK STREET AUBURN MANOR** CHASKA, MN 55318 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PRÉFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 441 Continued From page 16 F 441 Based on observation, interview and document Auburn Manor has established and review, the facility failed to ensure resident maintains an Infection Control Program equipment was clean and stored properly and designed to provide a safe, sanitary and gloves were disposed of properly for 4 of 4 comfortable environment and to help residents(R11, R16, R48, R63) reviewed for prevent the development and infection control. In addition, staff failed to transmission of disease and infection. properly handle dirty linens and use appropriate hand washing and gloving technique for 1 of 1 The survey team cited that the facility did resident (R31) observed during catheter care. not meet the requirement of ensuring that all resident equipment was clean and Findings include: stored properly and gloves were disposed of properly for four residents. In addition, During resident room observations on 7/13/15, at the survey team cited that in one case, 2:30 p.m. R63's commode was located in the one nursing assistant did not handle resident's room/living area. The lid to the soiled linens properly or use appropriate commode was unclean. R63's bed pan was also hand washing and gloving technique while stored for use on the bathroom floor at the time of providing urinary catheter care. the initial observation, as well as during subsequent observations on 7/14/15 and 7/15/15. Immediate remedial measures included On 7/13/15, at 4:00 p.m. R16 was sitting in a 'In Time' training on infection control recliner with a catheter bag positioned on the principles, including urinary catheter care, floor. On 7/13/15, at 4:30 p.m. Subsequent for the staff involved. All bedpans and observations on 7/15 and 7/16/15 revealed the urinals were immediately placed in measuring graduate for R48's catheter was appropriate coverings and stored away stored on the bathroom vanity, approximately 12 from clean supplies in all resident rooms. inches from the resident's toothbrush and toothpaste. Facility Wide Response Addressing Other In addition R11's toilet insert (for specimen Residents With the Potential to be collection) was stored on top of the bathroom sink Affected: on 7/15/15, at 8:45 a.m. The toilet cover was soiled and there were used gloves left on the floor 1. Facility direct care staff will receive an in the bathroom. educational infection control refresher which will include proper storage of clean When interviewed on 7/16/15, at 11:45 a.m. the resident equipment, appropriate glove infection control nurse stated all staff had been disposal, handling of soiled linens, urinary trained on use of standard precautions for catheter care, and any other infection infection control. She stated they had policies and control-related areas of concern. procedures on how to store and clean resident

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STATEMENT	OF DEFICIENCIES	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DAT	0938-039 E SURVEY PLETED
				IG		
		245604	B. WING _		07/	16/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	E	
				CHASKA, MN 55318		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 441	glove usage. She w described observed An undated Auburn policy noted directe objects should be p room and not to sto undated Catheter of should "never let th Infection Control Pr to maintain complia regulations relating reporting. The com program addressed control of infections personnel. Findings include: R31 was assisted w at 9:54 a.m. A nurs explained the proce raised the bed. NA- removed the cather was hooked to the pocket to retrieve a cleaned the end of urine into the toilet clip board explainin	as for hand washing and vas unaware of the situations d as above. Manor Home & Room order ed staff to store "no toileting blaced/visual throughout the ore anything on the floor." An Care policy specified staff the bag touch the floor." A 6/15, rogram indicated the goal was ance with state and federal to infection prevention and prehensive infection control d surveillance, prevention, and as among residents and with catheter cares on 7/16/15 sing assistant, (NA)-C edure, gathered supplies and -C donned gloves and ter bag from a pillowcase that bed. She reached into her an alcohol wipe. NA-C then the catheter bag, emptied the and recorded the findings on a an g she would transcribe the	F 44	 2. Gelled alcohol dispensers ar in each resident room and is us adjunct to hand washing when r The appropriate use of gelled a products will also be discussed infection control training session 3. Day-to-day compliance with infection control principles will b monitored and enforced by the nursing staff. 4. Ongoing: Quarterly random s audits of the proper cleaning an of residents' equipment will be of as part of the Resident and Roo audit process. Data obtained fr quality assurance process will b reviewed, with recommendation intervention made, during the qu quality assurance meetings for than one year. 	ed as an necessary. cohol at the ns. standard e icensed sample d storage conducted om Safety om the e s for uarterly	
	finished. NA-C rem hands and moved t with a mat on the fl find a staff member R31. At 10:03 she came prepared a basin o placed on the beds	e computer when she was oved her gloves, washed her the bed into the low position oor. She then left the room to r to assist with pericare for back into the room and f water and soap which she ide table. She donned gloves e. She did not wash per hands				

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/24/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245604	B. WING			07/	16/2015
NAME OF F	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AUBURN	MANOR				01 OAK STREET CHASKA, MN 55318		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 441	soiled wash cloth or removed the incont cream with a disposi- incontinence pad be then removed her s She again donned of hands, took a fresh and assisted R31 to upper body. Na-C p drawers to pick out intact. After R31 wa mouthpiece from th hands to ask for as- her recliner. When NA-C to transfer R3 use of a lift. After R NA-E placed the pil catheter on the floo and left the room. NA-C took the dirty plastic bag, emptied gloves When task was cor clumsy and didn't w explained she knew wash cloth on the b She verified she dic after the soiled was During an interview	finished, she placed the n the bedside table and inent pad, applied barrier sable cloth and placed a clean eneath R31. She removed	F 4	141	DEFICIENCY)		
	catheter was placed	ns, one since indwelling d when admitted to the after a fall. A urinary infection					

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		AND HUMAN SERVICES			FORM	08/24/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245604	B. WING		07 / [.]	16/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
AUBURN	I MANOR			501 OAK STREET CHASKA, MN 55318		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 441	of urine for a urinar A nursing note date for an antibiotic (Cip R31 's diagnosis lis dated 6/16/15 inclu- infection, infection of catheter, urine reter disease. The care plan dated monitor for signs ar	ed 7/14/15, noted the collection y analysis' ed 7/15/15 noted new orders pro) for R31. sted on careher care plan ded: history of urinary due to indwelling urine ntion and chronic kidney d 6/16/15 directs staff to nd symptoms of urinary tract	F 441			
	toileting and to prov policy. During an interview director of nursing (staff would not plac pericare on a bedsi hands before and a she was unclear if i their hands before a proceeding from a d "There has been ne need to see what of the facility's policy a handwashing, glovi care, the DON expl wash their hands be when going from a During an interview infection control nur expected infection of	assist with pericare and vide catheter cares per house on 7/16/15, at 10:42 a.m. the (DON) stated she expected be a washcloth used for de table and for staff to wash after a procedure. However, f staff was expected to wash and after gloving or when dirty to clean procedure, ew training on this and I will ur policy says." After review of and procedures regarding ng, pericare and catheter ained she did expect staff to efore and after gloving and dirty to clean procedure.				

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		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	08/24/2015 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE	E SURVEY PLETED
		245604	B. WING		07/	16/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
AUBURN	N MANOR			501 OAK STREET CHASKA, MN 55318		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRON DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 441	catheter care, incluse such as catheters of bedside table. She their hands before a explained staff is tra these areas The Auburn Manor undated, directs sta gloves before comit incontinent pad, and disposing of soiled appropriately. Was The Auburn Manor Pertinent Perineum from clean to dirty, wash hands and ap procedure. After pe	iding not placing equipment on the floor or dirty linen on a also expected staff to wash and after using gloves. She rained on an on-going basis in Catheter Care/Perineal Care, aff sanitize hands and don ing in contact with linen, id/or resident. Finish by linen/product/equipment	F 44			

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	MENT OF HEALTH	AND HUMAN SERV		-F50	604024	FOR	: 07/22/2015 A APPROVED). 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM	R/CLIA	(X2) MULTIP	LE CONSTRUCTION 6 01 - MAIN BUILDING 01	(X3) DATE S COMPL	URVEY
		245604		B. WING		07/	4/2015
	PROVIDER OR SUPPLIER N MANOR		501 OA	RESS, CITY, S K STREET (A, MN 553			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCI BE PRECEDED BY FULL I NTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	ſS		K 000			
	FIRE SAFETY						
	Minnesota Departm Marshal Division, of this survey, Building found in substantial requirements for pa Medicare/Medicaid 483.70(a), Life Safe edition of National F (NFPA) Standard 10	Survey was conduct nent of Public Safety, n July 14, 2015. At t g 01 of Auburn Mano compliance with the inticipation in at 42 CFR, Subpart ety from Fire, and the Fire Protection Assoc D1, Life Safety Code Health Care Occup	Fire he time of r was 2000 ciation (LSC),				
	building with no bas was constructed in addition constructed	rn Manor is a one-st sement. The original 1988, with one build d in 1992. Both build otected and were de) construction.	building ng lings are				
	detection in the corridors which is m department notifical separated from an a by complying two-ho	e alarm system with ridors and spaces op nonitored for automa tion. The nursing ho attached assisted liv our fire wall assembl ty of 61 beds and ha e of the survey.	ben to the tic fire ome is ing facility lies. The				
	RY DIRECTOR'S OR PROV		NTATIVE'S SIG	NATURE	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.

CENTERS FOR MEDICARE & MEDICAID SERVIC STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/IDENTIFICATION NUMB 245604 NAME OF PROVIDER OR SUPPLIER AUBURN MANOR				(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - 2006 ADDITION			(X3) DATE SURVEY COMPLETED	
			B. WING			07/14/2015		
			STREET ADDRESS, CITY, STATE, ZIP CODE 501 OAK STREET CHASKA, MN 55318					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATO OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
K 000	INITIAL COMMENT		K 000	nnn, 1-, 1-, 1-, 1-, 11, 10, 1-, -,				
	FIRE SAFETY							
	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, ha 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.		Fire he time of or was 2000 ciation (LSC), cies. f a 2006 height, has cted and smoke ben to the tic fire ome is ing facility lies. The					

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.

Station and the second