



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted
April 17, 2025

Administrator
Auburn Home In Waconia
594 Cherry Drive
Waconia, MN 55387

RE: CCN: 245583
Cycle Start Date: April 2, 2025

Dear Administrator:

On April 2, 2025, a survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On April 2, 2025, the situation of immediate jeopardy to potential health and safety cited at F578 - Request/Refuse/Dscntnue Trmnt;Formlte Adv. Dir. was removed. However, continued non-compliance remains at the lower scope and severity of D.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective May 2, 2025.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective May 2, 2025, (42 CFR 488.417 (b)), (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 2, 2025, (42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$13,343; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by May 2, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Auburn Home In Waconia will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 2, 2025. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the

deficient practice.

- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

LeAnn Huseh, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, MN 56537
Email: leann.huseh@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 2, 2025 (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.

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.

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <https://dab.efile.hhs.gov> no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at

(312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:

<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us



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Electronically delivered
April 17, 2025

Administrator
Auburn Home In Waconia
594 Cherry Drive
Waconia, MN 55387

Re: State Nursing Home Licensing Orders
Event ID: ZHJ111

Dear Administrator:

The above facility was surveyed on March 31, 2025 through April 2, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

LeAnn Huseeth, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, MN 56537
Email: leann.huseeth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

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

PRINTED: 04/30/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245583	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/02/2025
NAME OF PROVIDER OR SUPPLIER AUBURN HOME IN WACONIA			STREET ADDRESS, CITY, STATE, ZIP CODE 594 CHERRY DRIVE WACONIA, MN 55387		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
E 000	Initial Comments On 3/31/25 to 4/2/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000			
F 000	INITIAL COMMENTS On 3/31/25 to 4/2/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. In addition to the recertification survey, the following complaints were reviewed: The following complaints were reviewed with no deficiency issued: H55838361C (MN00109241), H55831120C (MN00111230). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/28/2025

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

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F 000	Continued From page 1	F 000			
F 577 SS=C	Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained. Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure that three years of survey results and the plan of correction	F 577			4/30/25
			1. The facility updated the survey results binder to include last three years of survey results and POC. These documents will		

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F 577	Continued From page 2 were readily accessible to residents or visitors. This deficient practice had the potential to affect all 32 residents currently residing in the facility. Findings include: During an observation on 4/1/25 at 12:00 p.m., the survey results binder was located on a shelf in a sitting area by the front door. The binder contained the last survey results noted from 2/29/24. The binder lacked the plan of correction for the 2/29/24, survey results. The binder lacked the survey results and plan of correction from the 12/1/22, survey. During a co-interview on 4/1/25 at 12:35 p.m., the administrator and director of nursing (DON) confirmed the most recent survey results from 2/29/24, were in the binder without the plan of correction and the plan of correction should have been included in the binder. The administrator and DON verified their process was to keep the most recent survey results in the binder and not the past three years. A policy on survey inspection results was requested and one was not provided.	F 577	remain readily available in a clearly labeled binder in a highly visible and accessible area in the front lobby. 2. The DON will be responsible for updating the binder within 5 days of receiving any new survey results or POC. 3. The DON will conduct 1 monthly audit for the next six months to ensure, all survey results and POCs from the past three years are in the binder, readily available and organized. Audit results will be reviewed during the facility's quarterly QAPI meetings for continued oversight.		
F 578 SS=J	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical	F 578			4/30/25

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F 578	Continued From page 3 services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure resident advance directives were accurately documented to reflect the resident's current wishes which affected 1 of 16 residents (R29) reviewed for advanced directives. This deficient practice	F 578			
			1. Immediate intervention included review of all resident POLST forms and ensured consistency across EHR and paper documentation, removal of code status from paper report forms to avoid conflicting information, educated all		

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F 578	Continued From page 4 resulted in an immediate jeopardy (IJ) for R29 who would have received cardiopulmonary resuscitation (CPR), contrary to their wishes, in the absence of a pulse or respirations. The IJ began on 1/9/25, when R29's updated physician's order for life sustaining treatment (POLST) signed on 1/9/25, identified R29's wishes of do not resuscitate (DNR). The three ring household binder and staff report form identified R29's wishes of CPR. The administrator and director of nursing (DON) were notified of the IJ on 4/1/25, at 3:35 p.m. The IJ was removed on 4/2/25, at 12:33 p.m., when the facility had implemented corrective action, however non-compliance remained at the lower scope and severity level of D, isolated with no actual harm but potential to cause more than minimal harm. Findings include: R29's quarterly Minimum Data Set (MDS) dated 3/14/25, identified R29 had moderately impaired cognition and had diagnoses which included atrial fibrillation (irregular heart rhythm), anemia, coronary artery disease (narrowing or blockage of the coronary arteries). R29 was dependent on staff for activities of daily living (ADLs) which included bed mobility, toileting, and transfers. R29's current POLST signed by family member (FM)-A on 1/9/25, identified R29's wishes were DNR. The POLST was scanned into his EHR and signed by his medical provider on 1/9/25. Review of R29's electronic health record (EHR) on 3/31/25 at 5:29 p.m., identified R9 wanted DNR.	F 578	current licensed staff on new documentation and verification protocols (utilizing EHR), mandated training completion prior to next shift via phone/text/email/in person notifications and confirmed that current facility policy supports resident rights and is included on the facilities orientation checklist. 2. All new residents since 4/1 have been audited for compliance. 3. All current, new and agency staff (nurses, TMA, CNAs) will be trained on the policy that includes locating the code status in the HER by 4/30/2025 end of day or their next scheduled shift 4. DON or designee to perform weekly audits x 6 weeks and monthly audits x 3 months of EHR code status documentation, staff knowledge on residents code status and where to locate it.		

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F 578	Continued From page 5 R29's care plan lacked documentation on resuscitation status. Review of a facility report form undated, located at the nurses station and carried by each nurse and nursing assistant identified R29 wanted CPR. Review of the household three ring binder located at the nurses station identified R29's POLST signed 6/11/24, R29 wanted CPR. During an interview on 3/31/25 at 6:31 p.m., FM-A stated he had signed the POLST on 1/9/25, identifying that R29's wishes were to be DNR. During an interview on 3/31/25 at 7:08 p.m., registered nurse (RN)-A indicated in the event a resident did not have a pulse or respirations, she would refer to the report form and would have proceeded accordingly. During an interview on 4/1/25 at 11:47 a.m., licensed practical nurse (LPN)-A indicated in the event a resident did not have a pulse or respirations, she would refer to the report form located in her pocket and would have proceeded accordingly. LPN-A verified R29's report sheet identified R29 wanted CPR. During an interview on 4/1/25 at 11:49 a.m., RN-B indicated in the event a resident did not have a pulse or respirations, she would refer to the three ring binder at the nurses desk and would have proceeded accordingly. RN-B verified R29's POLST in the binder identified R29 wanted CPR. RN-B verified there was a discrepancy between R29's EHR and the POLST in the binder and report form.	F 578			

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F 578	Continued From page 6 During an interview on 4/1/25 at 12:18 p.m., RN-C indicated in the event a resident did not have a pulse or respirations, she would refer to the three ring binder at the nurses desk and would have proceeded accordingly. RN-C verified R29's POLST in the binder identified R29 wanted CPR. RN-C verified there was a discrepancy between R29's EHR and the POLST in the binder and report form. During a interview on 4/1/25 at 2:15 p.m., DON stated a POLST was completed with all residents or resident representatives upon admission and was effective upon admission. DON confirmed there was a discrepancy with R29's EHR, the report form and three ring binder which identified R29 was a full code and did not match his current wishes of being DNR. DON confirmed in the event R29 did not have a pulse or respirations, CPR would have been initiated against R29's wishes. DON indicated she would expect staff to follow the POLST, resident wishes and the facility policy. Review of a facility policy titled Code Status Policy and Procedure, undated, identified the facility would follow a policy regarding a resident's right to request, refuse, and/or discontinue medical treatment and to formulate an advance directive. Identified the POLST would have been documented in the EHR and the household three ring binder. Further identified the code status would have been reviewed with Care Conferences at least quarterly and documented in the medical record. The IJ was removed on 4/2/25 at 12:33 p.m., when the facility developed and implemented a systemic removal plan which was verified by	F 578			

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F 578	Continued From page 7 interview and document review: -All residents' records were reviewed to ensure the POLST form and the electronic health records were updated to ensure resident's wishes for advance directives, were accurate on 4/2/25. -R29's three ring binder was updated to match the current POLST and the code status for all residents was removed from the report form. -All current licensed staff were educated on the policy for advance directives, updating the POLST, the EHR, and the three ring binder to reflect the resident's wishes on 4/2/25, as evidenced by the education sent to all nursing staff via email on 4/2/25 and interviews. -A process was implemented to assure all other nursing staff completed mandatory education prior to the start of their next shift on 4/2/25, by notification of required education via phone/text. All staff would sign off once education had been completed. -The advance directive policy was reviewed and determined no changes were required.	F 578			
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;	F 580			4/30/25

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F 580	Continued From page 8 (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations	F 580			

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F 580	Continued From page 9 under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide timely notification to a provider for change in condition related to falls for 1 of 1 resident (R23) reviewed for falls. Findings include: R23's quarterly Minimum Data Set (MDS) dated 3/7/25, identified R23 had moderately impaired cognition with diagnoses of type two diabetes with chronic kidney disease, anemia, coronary artery disease, arthritis, anxiety, difficulty in walking. Identified R23 required supervision with setup help for bed mobility, transfers, eating and limited assistance of staff for toilet use. R23's care plan dated 9/13/24, identified R23 had a mobility and self care deficit and at risk for falling related to impaired mobility, weakness, and an intellectual disorder. Staff were to monitor/document/report any changes. R23 required supervision or assist to transfer on and off toilet. R23 required supervision with transfers. Review of progress notes from 11/12/24 to 3/31/25, revealed the following: R23's progress note dated 11/12/24 at 2:27 a.m., identified R23's emergency contact was called and informed of R23's fall last night and health status. R23's progress notes lacked documentation of a fall on 11/11/24. R23's progress note dated 1/28/25 at 8:50 a.m., identified R23 was found on the floor laying next to the bed with wheelchair wheels against his			F 580	1. A head to toe assessment on affected resident was completed with no new injures noted. 2. Fall interventions and care plan reviewed, and resident representative and provider were updated of previous falls lacking documentation of notification by end of day 4/30/2025. 3. Audit of falls for the past 30 days of current residents will be conducted and any deficiencies found corrected by end of day 4/30/2025. 4. The fall policy was reviewed with no changes needed. 5. On 4/30/25 the DON or designee will re-educate all licensed nurses, CNAs, and relevant staff on the revised fall policy and notification requirements. New employees and agency staff will receive training during orientation. 6. DON or designee will conduct random audits of fall incidents weekly for 6 weeks, then monthly for 3 months to ensure proper documentation and notifications were completed. Any deficiencies will result in immediate re-education and corrective action. Audit results will be reviewed in quarterly QAPI meetings ongoing.		

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F 580	Continued From page 10 back. Staff helped pick R23 up from the floor and took R23 to the bathroom. R23 slipped out of the wheelchair in front of the toilet. Staff picked R23 up and placed R23 on the toilet. R23's progress note dated 2/24/25 at 14:43 p.m., identified R23 was found on the floor in front of the toilet. Staff assisted R23 into wheelchair and then onto the toilet. A follow up note at 4:16 p.m., identified R23's guardian was updated on R23's fall. R23's progress note dated 3/31/25 at 10:18 a.m., R23 was found on the floor in the bathroom. Staff reminded R23 to use the call light before transfers, vitals obtained. R23's progress note dated 3/31/25 at 10:23 a.m., R23 again found sitting on floor in front of toilet. Vitals obtained and diabetic shoes put on for better traction. R23's progress notes lacked documentation the provider had been notified. During an interview on 4/1/25 at 11:47 a.m., licensed practical nurse (LPN)-A stated R23 had a history of falls. LPN-A stated staff were to supervise R23 with toileting and assist as needed. LPN-A stated staff were expected to report a fall, ensure the resident was safe, call provider if suspected injury, complete an incident report and update provider and representative. During an interview on 4/1/25 at 11:49 a.m., RN-B confirmed staff were expected to ensure a resident was safe after a fall, complete an incident/investigation report, update provider and resident representative.	F 580			

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F 580	Continued From page 11 A voicemail was left for R23's guardian on 4/2/25 at 2:07 p.m., with no return call. During an interview on 4/2/25 at 2:22 p.m., DON verified R23 had a history of falls. DON confirmed the provider had not been updated on the above falls for R23. DON stated expectations of staff were to ensure resident was safe and not injured after a fall, complete an incident/investigation report and update provider and resident representative. DON confirmed that was important to prevent further falls and ensure the provider and representative were notified. A facility policy titled Accident: Managing Resident Falls, reviewed 7/10/24, identified a fall was defined as an unintentional change in position coming to rest on the ground, floor, or onto the next lower surface. The policy identified a licensed nurse would be notified and evaluate the condition of the resident. Staff were to notify resident representative. Staff were to notify the provider if injury suspected or noted, head strike and on anticoagulants. The policy lacked documentation that a provider would be notified of a fall regardless of injury.	F 580			
F 585 SS=F	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been	F 585			4/30/25

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F 585	Continued From page 12 furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;			F 585			

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F 585	Continued From page 13 (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency	F 585			

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F 585	Continued From page 14 confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure grievance forms and procedures were posted in prominent locations throughout the facility for residents and resident representatives to file grievances, and anonymously if desired for 4 of 4 residents (R18, R16, R19, and R7) reviewed for grievances. Findings include: On 3/31/25 at 11:00 a.m., a resident council meeting was held with four residents which included R18, R16, R19, and R7. During the resident council meeting, all four residents indicated they were unaware of how to file a grievance. During an observation on 3/31/25 at 12:00 p.m., the surveyor could not locate grievance forms throughout the facility. During a joint interview on 4/1/25 at 12:35 p.m., the administrator and director of nursing (DON) both confirmed the grievances were kept in the social service office. During an interview on 3/31/25 at 2:38 p.m., social services director (SSD) confirmed there were grievances in her office and was unable to locate grievances that were posted in prominent locations for the residents or resident	F 585	1. Grievance forms were immediately placed in clearly visible and accessible areas in the front lobby. Additionally, there is a clearly labeled and secure drop box that allows for anonymous submission. 2. On 4/20/2025 residents were educated on their right to file grievances, how to do so anonymously, and where forms and drop boxes are now located during monthly resident council meeting. 3. The social services staff or designee will check drop box weekly and address any submissions. 4. Additionally, the social services staff will perform weekly audits for 6 weeks, then monthly for 3 months to ensure grievance forms and boxes remain accessible in designated areas and that submissions are being collected and addressed timely. Audit results will be reviewed in the facility's monthly QAPI meeting. Continued monitoring will be determined based on audit findings.		

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F 585	Continued From page 15 representatives to file grievances anonymously. During an interview on 4/1/25 at 3:46 p.m., registered nurse (RN)-A confirmed that grievance forms were kept in the social service office and unaware if there were grievances posted in prominent locations for the residents or resident representatives to file grievances anonymously. Review of facility form titled Grievance, Complaint and Non-Retaliation Policy, dated 1/2522, stated If an informal resolution could not be found, the resident would be offered the opportunity to file a formal complaint utilizing a grievance report form. The resident may file a grievance orally to an employee. The employee was to complete the grievance report form with the resident's oral report. The resident could file a grievance anonymously. The grievance would be forwarded to the grievance official for review within a reasonably expected timeframe. The grievance official would work with the resident, the resident's representative, the department manager, and the director of nursing and Social Services to work toward an acceptable solution. The facility Grievance policy updated 1/25/22, lacked documentation on how grievances could be filed anonymously or how to obtain a grievance form other than talking to staff.	F 585			
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations	F 609			4/30/25

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F 609	Continued From page 16 involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to report a bruise of unknown origin to the State Agency (SA) for 1 of 1 resident (R23) reviewed for falls. Findings include: R23's quarterly Minimum Data Set (MDS) dated 3/7/25, identified R23 had moderately impaired cognition with diagnoses of type two diabetes with chronic kidney disease, anemia, coronary artery disease, arthritis, anxiety, difficulty in walking. Identified R23 required supervision with setup help for bed mobility, transfers, eating and limited			F 609	1. A head to toe assessment on affected resident was completed with no new injures noted. 2. All current residents progress notes for the past 30 days reviewed for any symptoms of injury of unknown origin to ensure proper reporting and any investigation warranted was completed. 3. Facility reviewed VA policy which includes specific timelines for reporting suspected abuse (which includes signs of injury of unknown origin) or serious bodily injury. No changes needed. 4. In-service training will be held on		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245583	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/02/2025
NAME OF PROVIDER OR SUPPLIER AUBURN HOME IN WACONIA			STREET ADDRESS, CITY, STATE, ZIP CODE 594 CHERRY DRIVE WACONIA, MN 55387		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 609	Continued From page 17 assistance of staff for toilet use. R23's care plan dated 9/13/24, identified R23 had a mobility and self care deficit related to impaired mobility, weakness, and an intellectual disorder. Staff were to monitor/document/report any changes. R23's care plan lacked documentation on skin care and monitoring. Review of R23's progress notes from 11/12/24 to 3/31/25, revealed the following: R23's nursing progress note dated 11/20/24 at 9:35 p.m., stated R23 had a large purple bruise to the right hip/buttock area measuring approximately 20 centimeter (cm) by 15 cm and a smaller red bruise to the left hip measuring approximately five cm by five cm. R23 stated he did not know how he obtained the bruises. R23's nursing progress note dated 1/18/25 at 2:30 p.m., stated R23 had a four cm by ten cm medium purple contusion on lower sacral (buttock) area. R23 stated he did not recall a injury. Origin unknown. An investigation into causative factors and analysis of R23's bruises was requested and was not received. During an interview on 4/1/25 at 11:47 a.m., licensed practical nurse (LPN)-A stated she was unaware of R23 having any bruises. LPN-A stated she would report to the registered nurse (RN) any bruises or injury of unknown origin and update the doctor. During an interview on 4/1/25 at 11:49 a.m., RN-B stated she was unaware of R23 having any	F 609	4/30/25 for all nursing staff, focusing on identifying and documenting injuries of unknown origin, immediate reporting protocols, as well as completing incident and investigation reports thoroughly. New staff to receive mandatory orientation training on abuse and incident reporting protocols and has been added to orientation checklist. 5. Weekly audits by DON or designee for 6 weeks and monthly x 3 months of all resident progress notes and skin assessments to identify any undocumented injuries or gaps in reporting. Any findings will trigger immediate investigation and appropriate reporting. Immediate retraining will also be done. Results will be reviewed during quarterly QAPI meetings.		

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F 609	Continued From page 18 bruises. RN-B stated she would report to the director of nursing (DON) any bruises or injury of unknown origin and complete an investigation report. A voicemail was left for R23's guardian on 4/2/25 at 2:07 p.m., with no return call. During an interview on 4/2/25 at 2:22 p.m., DON stated she was unaware of R23 having any bruises. DON confirmed a report to the SA had not been filed and should have been. DON verified the expectation of staff was to complete an incident report, update the doctor and resident representative and follow up with an investigation report. DON stated that was important for resident safety and to ensure no further bruising or deterioration. During an interview on 4/2/25 at 2:37 p.m., administrator stated she was unaware R23 had any bruises. A facility policy on reporting was requested and not received.			F 609			
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.			F 610			5/5/25

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F 610	Continued From page 19 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to investigate a bruise of unknown origin for 1 of 1 resident (R23) reviewed for falls. Findings include: R23's quarterly Minimum Data Set (MDS) dated 3/7/25, identified R23 had moderately impaired cognition with diagnoses of type two diabetes with chronic kidney disease, anemia, coronary artery disease, arthritis, anxiety, difficulty in walking. Identified R23 required supervision with setup help for bed mobility, transfers, eating and limited assistance of staff for toilet use. R23's care plan dated 9/13/24, identified R23 had a mobility and self care deficit related to impaired mobility, weakness, and an intellectual disorder. Staff were to monitor/document/report any changes. R23's care plan lacked documentation on skin care and monitoring. Review of R23's progress notes from 11/12/24 to 3/31/25, revealed the following: R23's nursing progress note dated 11/20/24 at 9:35 p.m., stated R23 had a large purple bruise to the right hip/buttock area measuring approximately 20 centimeter (cm) by 15 cm and a			F 610	1. A head to toe assessment on affected resident was completed with no current injures of unknown origin noted. Resident has no ongoing concerns of injury related to bruises documented in progress notes on 11/20/2024 or 1/18/2025. 2. Facility reviewed VA policy which includes specific timelines for reporting suspected abuse (which includes signs of injury of unknown origin) or serious bodily injury as well as reporting to state agency and investigation expectations. Per policy, the DON or Social Services are responsible to complete the investigation and report findings to the state agency within 5 working days. No changes needed. 3. In-service training will be held on 4/30/25 for all nursing staff & social services, focusing on identifying and documenting injuries of unknown origin, immediate reporting protocols, as well as completing incident and investigation reports thoroughly. Nursing staff not present at the in-service on 4/30/3025 will be trained at the start of their next scheduled shift. New staff to receive mandatory orientation training on abuse		

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F 610	Continued From page 20 smaller red bruise to the left hip measuring approximately five cm by five cm. R23 stated he did not know how he obtained the bruises. R23's nursing progress note dated 1/18/25 at 2:30 p.m., stated R23 had a four cm by ten cm medium purple contusion on lower sacral (buttock) area. R23 stated he did not recall a injury. Origin unknown. An investigation into causative factors and analysis of R23's bruises was requested and was not received. During an interview on 4/1/25 at 11:47 a.m., licensed practical nurse (LPN)-A stated she was unaware of R23 having any bruises. LPN-A stated she would report to the registered nurse (RN) any bruises or injury of unknown origin and update the doctor. During an interview on 4/1/25 at 11:49 a.m., RN-B stated she was unaware of R23 having any bruises. RN-B stated she would report to the director of nursing (DON) any bruises or injury of unknown origin and complete an investigation report. A voicemail was left for R23's guardian on 4/2/25 at 2:07 p.m., with no return call. During an interview on 4/2/25 at 2:22 p.m., DON stated she was unaware of R23 having any bruises. DON confirmed an investigation had not been completed. DON verified the expectation of staff was to complete an incident report, update the doctor and resident representative and follow up with an investigation report. DON stated it was important for resident safety and to ensure			F 610	and incident reporting protocols and has been added to orientation checklist. 4. Weekly audits by DON or designee for 6 weeks and monthly x 3 months of all resident progress notes and skin assessments to identify any undocumented injuries or gaps in reporting. Any findings will trigger immediate investigation and appropriate reporting. Immediate retraining will also be done. Results will be reviewed during quarterly QAPI meetings.		

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F 610	Continued From page 21 no further bruising or deterioration occurred. During an interview on 4/2/25 at 2:37 p.m., administrator stated she was unaware R23 had any bruises. Administrator confirmed an investigation had not been completed. A facility policy on reporting and investigation was requested and not received.			F 610			
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide assistance with routine grooming care which included facial hair removal for 3 of 3 residents (R7, R12, R3) reviewed for activities of daily living (ADLs) who required assistance with grooming and personal hygiene. Findings include: R7 R7's quarterly Minimum Data Set (MDS) dated 3/31/25, identified R7 as being cognitively intact, and diagnoses which included heart failure, asthma, macular degeneration (vision loss), and dysphagia (difficulty swallowing). R7 required moderate assistance for personal hygiene which included washing and drying face, shaving, and combing hair.			F 677	1. Residents affected were asked for their grooming preferences, including shaving frequency and specific needs, which were documented and added to their care plans. 2. Nurse Manager trained on comprehensive person-centered care planning on 4/28/25 including resident personal preferences must be documented on the care plan upon admission and reviewed quarterly and/or with any change in condition. 3. All resident care plans will be reviewed to ensure ADL preferences, including shaving are clearly documented by 4/30/25. 4. Nursing staff training on where to find resident ADL and grooming preferences provided during in service on 4/30/25 or at the start of their next scheduled shift. All		4/30/25

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F 677	Continued From page 22 R7's care plan revised on 11/4/24, identified R7 requires moderate assistance with personal hygiene. During an observation on 3/31/25 at 4:28 p.m., R7 had .25 centimeters (cm) of hair growth on the cheeks, chin, neck, and upper lips. During an observation on 4/1/25 at 8:11 a.m., R7 was sitting at the breakfast table and continued to have 0.25 cm of hair growth on their face and neck. During an observation on 4/1/25 at 3:50 p.m., R7 was sitting in his room and continued to have 0.25 cm of hair growth on his face and neck. During an interview on 3/31/25 at 4:28 p.m., R7 stated that he would like to be shaved daily. During an interview on 4/1/25 at 4:00 p.m., nursing assistant (NA)-A indicated he was unsure how often R7 would like to be shaved. NA-A reported it was his second shift at the facility and was unaware of how often residents were to be shaved but would assume it would be on a resident's bath day. During an interview on 4/2/25 at 7:18 a.m., NA-B indicated she was unaware of how often R7 would like to be shaved. NA-B indicated residents should have been offered to be shaved on their bath day. NA-B reported it was her first shift at the facility. During an interview on 4/2/25 at 8:01 a.m., NA-C indicated R7 needed assistance with ADLs. NA-C reported R7 was shaved on his bath day and	F 677	new hires will receive training on resident ADL preferences during orientation per orientation checklist. 5. DON or designee will perform weekly audits x 6 weeks and monthly x 3 months of 2 resident care plans and documentation of their cares received to ensure personal preferences are being honored. Review of audit findings will be discussed at quarterly QAPI meeting.		

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F 677	Continued From page 23 would need to request if he wants to be shaved in addition to once a week. During an interview on 4/1/25 at 4:11 p.m., registered nurse (RN)-A indicated it was her expectation residents were shaved every morning. RN-A verified that R7 had facial hair and should have been offered assistance with grooming. R12 R12's significant change MDS dated 4/4/25, identified R12 as severely cognitively impaired with diagnoses which included dementia, muscle weakness, and peripheral vascular disease (a progressive disorder of the blood vessels). Identified R12 required maximal assistance for personal hygiene which included washing their face, shaving, and combing their hair. R12's care plan revised on 10/11/24, identified R12 required physical assistance with ADLS and mobility on more than a daily basis. During an observation on 3/31/25 at 4:40 p.m., R12 had one cm of hair growth on the face, upper lip, cheeks, and neck. During an observation on 4/1/25 at 8:11 a.m., R12 was sitting at the breakfast table dressed. R12 had not been shaved and continued to have one cm of facial hair on the face and neck. During an observation on 4/1/25 at 3:49 p.m., R12 was in his room and continued to have one cm of facial hair on his face and neck. During an interview on 3/31/25 at 4:40 p.m., R12	F 677			

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F 677	Continued From page 24 indicated he would like to be shaved daily. During an interview on 4/1/25 at 4:00 p.m., nursing assistant (NA)-A indicated he was unaware of how often R12 liked to be shaved. NA-A reported it was his second shift at the facility and was unaware of how often residents were to be shaved but would assume it would be on a resident's bath day. During an interview on 4/2/25 at 7:18 a.m., NA-B indicated she was unaware of how often R12 would like to be shaved. NA-B indicated residents should have been offered the resident's bath day once a week. NA-B reported it was her first shift at the facility. During an interview on 4/1/25 at 4:11 p.m., RN-A indicated it was her expectation residents were shaved every morning. RN-A went into R12's room and verified that R12 had facial hair around one cm. long. R12 told RN-A he wanted his beard shaved today. During an interview on 4/2/25 at 8:01 a.m., NA-C indicated R12 required assistance with ADLs and was shaved on his bath day. R3 R3 admission MDS dated 2/17/25, identified R3 as severely cognitively impaired with a diagnosis that included Parkinson ' s (brain disorder that causes problems with movement, balance, and coordination), dementia, and diabetes (a disease that affects how the body uses blood sugars). Identified R3 as being on hospice and needing supervision or touching assistance for combing hair, shaving, washing face and hands.	F 677			

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F 677	Continued From page 25 R3 care plan revised on 2/19/25, identified R3 required supervision or touching assistance for personal care. During an observation on 3/31/25 at 3:00 p.m., R3 was sleeping in his room and noted to have two cm of facial hair on cheeks, chin, and neck. During an observation on 4/1/25 at 8:13 a.m., R3 was sitting at the breakfast table sleeping. R3 was dressed and continued to have two cm length of facial hair on face and neck. During an observation on 4/1/25 at 3:27 p.m., R3 was sitting in his bedroom in his wheelchair sleeping. R3 continued to have two cm length of facial hair on the face and neck. During an interview on 3/31/25 at 3:00 p.m., with power of attorney (POA) indicated R3 would like to be shaved daily. R3 shaved daily when living at home and having facial hair would bother him. During an interview on 4/1/25 at 4:00 p.m., nursing assistant (NA)-A indicated he was unaware of how often R3 liked to be shaved. NA-A reported it was his second shift at the facility and was unaware of how often residents were to be shaved but would assume it would be on a resident's bath day. During an interview on 4/2/25 at 7:18 a.m., NA-B indicated she was unaware of how often R3 would like to be shaved. NA-B indicated residents were offered to be shaved on the resident's bath day once a week. NA-B reported it was her first shift at the facility.	F 677			

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F 677	Continued From page 26 During an interview on 4/1/25 at 4:11 p.m., RN-A went into R3's room and verified that R12 had facial hair around two cm in length of facial hair. During an interview on 4/2/25 at 8:01 a.m., NA-C indicated R3 required assistance with ADLs and was shaved on his bath day. During an interview on 4/2/25 at 9:02 a.m., director of nursing (DON) indicated residents were shaved on their bath day which was normally once a week. DON was unaware if residents were asked what their preference was with shaving on admission. The DON was unsure if their preference on how often they would like to be shaved was included in the care plan. The DON expectation would be to ask residents what their preference was for shaving and placing the resident's preference in the care plan.	F 677			
F 684 SS=D	A policy for grooming and/or ADL care was requested and non was provided. Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively assess and	F 684			4/30/25
			1. Nurse Manager retrained on completing comprehensive person		

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F 684	Continued From page 27 monitor a bruise of unknown origin for 1 of 1 resident (R23) reviewed for falls. Findings include: R23's quarterly Minimum Data Set (MDS) dated 3/7/25, identified R23 had moderately impaired cognition with diagnoses of type two diabetes with chronic kidney disease, anemia, coronary artery disease, arthritis, anxiety, difficulty in walking. Identified R23 required supervision with setup help for bed mobility, transfers, eating and limited assistance of staff for toilet use. R23's care plan dated 9/13/24, identified R23 had a mobility and self care deficit related to impaired mobility, weakness, and an intellectual disorder. Staff were to monitor/document/report any changes. R23's care plan lacked documentation on skin care and monitoring. Review of R23's progress notes from 11/12/24 to 3/31/25, revealed the following: R23's nursing progress note dated 11/20/24 at 9:35 p.m., stated R23 had a large purple bruise to the right hip/buttock area measuring approximately 20 centimeter (cm) by 15 cm and a smaller red bruise to the left hip measuring approximately five cm by five cm. R23 stated he did not know how he obtained the bruises. R23's nursing progress note dated 1/18/25 at 2:30 p.m., stated R23 had a four cm by ten cm medium purple contusion on lower sacral (buttock) area. R23 stated he did not recall a injury. Origin unknown. R23's nursing progress note dated 3/11/25 at 2:11	F 684	centered care plans. 2. A head to toe assessment on affected resident was completed with no new injures noted. 3. Fall interventions and care plan reviewed, and resident representative was updated of previous falls lacking documentation of notification by end of day 4/30/2025. 4. Audit of falls for the past 30 days of current residents will be conducted as well as ensuring any interventions are care planned by 4/30/2025. 5. The fall policy was reviewed with no changes needed. 6. On 4/30/25 the DON or designee will re-educate all licensed nurses, CNAs, and relevant staff on the revised fall policy and notification requirements. New employees and agency staff will receive training during orientation. 7. DON or designee will conduct random audits of fall incidents weekly for 6 weeks, then monthly for 3 months to ensure any fall interventions implemented are added to care plan. Any deficiencies will result in immediate re-education and corrective action. Audit results will be reviewed in quarterly QAPI meetings ongoing.		

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F 684	Continued From page 28 p.m., stated R23 had a large bruise on lower back- football size. R23 stated the bruise was from hitting the arm of the wheelchair. R23's progress notes lacked comprehensive assessments and monitoring of the large bruises. An investigation into causative factors and analysis of R23's bruises was requested and was not received. During an interview on 4/1/25 at 11:47 a.m., licensed practical nurse (LPN)-A stated she was unaware of R23 having any bruises. LPN-A stated she would report to the registered nurse (RN) any bruises or injury of unknown origin and update the doctor. During an interview on 4/1/25 at 11:49 a.m., RN-B stated she was unaware of R23 having any bruises. RN-B stated she would report to the director of nursing (DON) any bruises or injury of unknown origin and complete a comprehensive assessment and investigation report. RN-B verified a comprehensive assessment and monitoring of R23's bruises had not been completed. A voicemail was left for R23's guardian on 4/2/25 at 2:07 p.m., with no return call. During an interview on 4/2/25 at 2:22 p.m., DON stated she was unaware of R23 having any bruises. DON verified the expectation of staff was to complete an incident report, update the doctor and resident representative and follow up with an investigation report. DON confirmed a comprehensive assessment and monitoring of R23's bruises had not been completed. DON			F 684			

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F 684	Continued From page 29 stated assessments and ongoing monitoring was important for resident safety and to ensure no further bruising or deterioration occurred. A facility policy on comprehensive assessments was requested and not received.	F 684			
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a comprehensive assessment (fall scene investigation) and a review or adjustment of the current fall prevention interventions to prevent falls for 1 of 1 residents (R23) who had multiple falls within the facility reviewed for falls. Findings include: R23's quarterly Minimum Data Set (MDS) dated 3/7/25, identified R23 had moderately impaired cognition with diagnoses of type two diabetes with chronic kidney disease, anemia, coronary artery disease, arthritis, anxiety, difficulty in walking. Identified R23 required supervision with setup help for bed mobility, transfers, eating and limited assistance of staff for toilet use.	F 689			5/5/25
			1. Fall scene investigation form completed documenting a summary of falls since 1/1/2025. This will be reviewed in IDT and any new interventions documented and care planned. Resident has received injections in his knees by his provider 4/2025. 2. All clinical staff trained on managing falls policy, including reporting requirements, completing the fall scene investigation under risk management in PCC, implementing immediate interventions, updating the care plan and review of falls at next IDT to ensure interventions implemented are appropriate and address the root cause during in-service on 4/30/2025 or the start of their next scheduled shift. 3. Audit of falls for the past 30 days of		

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F 689	Continued From page 30 R23's care plan dated 9/13/24, identified R23 had a mobility and self care deficit and at risk for falling related to impaired mobility, weakness, history of falls, and an intellectual disorder. R23 required supervision or assist to transfer on and off toilet. R23 required supervision with transfers. Staff were to monitor/document/report any changes. Review of R23's progress notes from 11/12/24 to 3/31/25, revealed the following: -On 11/7/24 at 8:31 a.m., identified R23 was found on the floor in the bathroom. R23 was reminded to use the call light and wait for assistance. The progress note lacked a fall scene investigation to evaluate the root cause of the fall and implement or change interventions on the plan of care. -On 11/12/24 at 2:27 p.m., identified R23's emergency contact was called and informed of R23's fall last night and health status. R23's progress notes lack documentation of a fall on 11/11/24 and a fall scene investigation to evaluate the root cause of the fall and implement or change interventions on the plan of care. -On 12/17/24 at 6:30 a.m., identified R23 stated he hit his head on the bathroom wall while self transferring from toilet to wheelchair. R23 was sent to the emergency department for evaluation. A follow up progress note on 12/17/24 at 12:03 p.m., identified R23 returned from the emergency department and presented with his usual mental and physical abilities. R23 had a contusion on the left knee and pain in the right hip, received Tylenol. No contusion present on R23's head. The progress note lacked a fall scene	F 689	current residents will be conducted to ensure the fall scene investigation was completed, immediate interventions implemented, care plan updated and IDT review completed. Any deficiencies found will corrected by end of day 4/30/2025. 4. DON or designee will conduct random audits of fall incidents ensuring completed under risk management, immediate interventions were implemented, care plan was updated and was reviewed at IDT weekly for 6 weeks, then monthly for 3 months. Any deficiencies will result in immediate re-education and corrective action. Audit results will be reviewed in quarterly QAPI meetings ongoing.		

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F 689	Continued From page 31 investigation to evaluate the root cause of the fall and implement or change interventions on the plan of care. -On 1/5/25 at 5:30 a.m., identified R23 was found on the floor next to the bed. R23 was assisted into the wheelchair and confirmed no injuries. The progress note lacked a fall scene investigation to evaluate the root cause of the fall and implement or change interventions on the plan of care. -On 1/27/25 at 7:04 p.m., identified R23 was on the floor with no injury noted. Staff reminded R23 to call for assistance. The progress note lacked a fall scene investigation to evaluate the root cause of the fall and implement or change interventions on the plan of care. -On 1/28/25 at 8:50 a.m., identified R23 was found on the floor laying next to the bed with wheelchair wheels against his back. Staff helped pick R23 up from the floor and took R23 to the bathroom. R23 then slipped out of the wheelchair in front of the toilet. Staff picked R23 up and placed R23 on the toilet. The progress note lacked a fall scene investigation to evaluate the root cause of the fall and implement or change interventions on the plan of care. -On 2/24/25 at 14:43 p.m., identified R23 was found on the floor in front of the toilet. Staff assisted R23 into wheelchair and then onto the toilet. The progress note lacked a fall scene investigation to evaluate the root cause of the fall and implement or change interventions on the plan of care. -On 3/6/25 at 14:40 p.m., identified R23 fell in the bathroom for the second time. After the second	F 689			

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F 689	Continued From page 32 fall R23 stated his right knee hurt. The progress notes lacked documentation of a first fall on 3/6/25 and further lacked a fall scene investigation to evaluate the root cause of both falls and implement or change interventions on the plan of care. -On 3/31/25 at 10:18 a.m., R23 was found on the floor in the bathroom. Staff reminded R23 to use the call light before transfers, vitals obtained. The progress note lacked a fall scene investigation to evaluate the root cause of the fall and implement or change interventions on the plan of care. -On 3/31/25 at 10:23 a.m., R23 again found sitting on floor in front of toilet. Vitals obtained and diabetic shoes put on for better traction. The progress note lacked a fall scene investigation to evaluate the root cause of the fall. During an interview on 4/1/25 at 11:47 a.m., licensed practical nurse (LPN)-A stated R23 had a history of falls. LPN-A stated staff were to supervise R23 with toileting and assist as needed. LPN-A stated a falls assessment would be completed and an intervention put in place. During an interview on 4/1/25 at 11:49 a.m., RN-B confirmed the above falls occurred for R23. RN-B verified a falls assessment identified as a fall scene investigation was to be completed after each fall to identify the root cause of the fall and an intervention would be implemented on the care plan to prevent further falls. RN-B confirmed a fall scene investigation and new care plan interventions were not completed for the above falls. During an interview on 4/2/25 at 11:51 a.m.,	F 689			

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F 689	Continued From page 33 physical therapist (PT) verified R23 was receiving therapy for strengthening and falls. PT stated therapy was working with R23 on standing tolerance as R23 had many falls in the bathroom. PT confirmed R23 was not to be independent in the bathroom and to have staff assistance. During an interview on 4/2/25 at 2:22 p.m., DON verified R23 had a history of falls and verified the above falls occurred. DON confirmed a fall scene investigation and care plan interventions were note completed for the above falls. DON stated expectations of staff were to ensure resident was safe and not injured after a fall, complete a falls scene investigation to evaluate and implement or change interventions on the plan of care. DON confirmed that was important to prevent further falls and injury. A facility policy titled Accident: Managing Resident Falls, reviewed 7/10/24, identified a fall was defined as an unintentional change in position coming to rest on the ground, floor, or onto the next lower surface. The policy identified a licensed nurse would be notified and evaluate the condition of the resident. The staff in conjunction with the interdisciplinary team (IDT), resident and or resident representative would implement the residents plan of care with interventions to reduce the risk of falls. Following a fall, staff would initiate a fall scene investigation to evaluate and implement or change interventions on the plan of care to minimize serious consequences of falling. Immediate interventions implemented or changed to prevent additional falls must be documented on the fall scene investigation form. IDT would review all falls and interventions implemented to further reduce the risk of additional falls.	F 689			

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F 757 F 757 SS=D	Continued From page 34 Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to identify diagnoses or indications for use of medications for 1 of 6 residents (R15) reviewed for unnecessary medications. Findings include: R15's admission Minimum Data Set (MDS) dated 1/20/25, identified R15 had intact cognition with diagnoses of chronic heart failure, chronic kidney disease, atrial fibrillation. Identified R15 required supervision with setup help for activities of daily			F 757 F 757	1. For R15 is no longer a resident of facility. 2. Audit of current resident medications for prophylactic antibiotic use to ensure documented diagnosis and indication of use will be completed by end of day 4/30/25 and any other residents affected will be corrected. 3. The consultant pharmacist will conduct monthly antibiotic reviews to, ensure all prophylactic antibiotics have a documented diagnosis and indication,		5/5/25

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F 757	Continued From page 35 living (ADL's). R15's physician's orders and oncology notes were requested and not received. R15's medication administration record (MAR) dated 3/2025, included the following medication but lacked diagnoses or ongoing need for use: -Bactrim DS 800-160 milligrams (mg). Give one tablet by mouth in the morning every Monday, Wednesday, Friday for due to high dose of steroids. Bactrim order initiated 1/15/25. During an interview on on 4/2/25 at 12:58 p.m., RN-B verified R15 had been receiving Bactrim DS 800-160 mg since 1/15/25, and the medication had not been reviewed for unnecessary medications at this time. During an interview on 4/2/25 at 1:48 p.m., pharmacy consultant (PC) stated the facility starting working with the facility three months ago. PC verified R15 was on Bactrim DS 800-160 mg and R15 had been receiving the medication since 1/15/25. PC stated the facility had not established an antibiotic stewardship program with him yet to review antibiotics monthly during his visit. PC confirmed antibiotics would only be used as ordered by a physician and would not be used long term unless indicated. During an interview on 4/2/25 at 1:50 p.m., nurse practitioner (NP) stated Bactrim DS 800-160 mg was not identified on R15's medication list on file at the clinic. NP verified if the Bactrim order was on the current medication file it would have been reviewed at each physician visit to determine if the medication could be discontinued. NP			F 757	monitor duration of therapy and recommend discontinuation or adjustment as necessary. Consulting pharmacist will also review residents for unnecessary medications and make any recommendations to the resident's provider. 5. The DON or designee will conduct a monthly audit for 6 months of resident monthly pharmacy reviews and recommendations to ensure pharmacist is completing monthly antibiotic reviews as well as any recommendations are being follow-up by the provider. Should the DON not receive any documentation of the pharmacist antibiotic reviews with the monthly pharmacy consultation notes, she will email the consulting pharmacist for documentation. All findings will be reviewed during the quarterly QAPI meeting. Any discrepancies will be addressed with immediate physician follow-up and staff retraining.		

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F 757	Continued From page 36 confirmed the expectation of the facility would be to review antibiotics monthly and since R15's steroid use had been decreased over the past few months the Bactrim should have been discontinued. NP verified that was important to review and discontinue unnecessary medications for a resident to prevent unnecessary medication use. During an interview on 4/2/25 at 2:18 p.m., director of nursing (DON) verified R15 was receiving Bactrim DS 800-160 mg three times a week since 1/15/25. DON confirmed R15 was not being monitored or reviewed for unnecessary medication use monthly with the pharmacist or on the facility antibiotic tracking system. The facility did not currently have an infection preventionist to track and monitor unnecessary antibiotic use. DON verified the expectation of the facility was to monitor each resident for unnecessary medications at least monthly to prevent unnecessary medication use. A facility policy on medication administration and unnecessary medication use was requested and not received. A facility policy titled Antibiotic Stewardship Program reviewed 2/2020, identified the policy to maintain an antibiotic stewardship program with the mission of promoting the appropriate use of antibiotics to treat infections and reduce possible adverse events associated with antibiotic use. The medical director, nursing team and consultant pharmacist would be responsible for promoting the program.	F 757			
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812			5/5/25

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F 812	Continued From page 37 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure food items were properly labeled and dated after packaging was opened and were disposed of after the expiration date to prevent cross contamination. In addition, the facility failed to maintain a clean and sanitary kitchen area. This deficient practice had the potential to affect all 32 residents currently residing in the facility. Findings Include: During an initial tour of the kitchen and kitchenettes on 3/31/25 at 2:10 p.m., with dietary manager (DM)-A, the following areas of concern were identified:			F 812	1. Ensure labeling and Dating: Continued training and conducting in-service for staff as to why, how and when to properly label and date items and food will be completed by 4/30/2025 or at the start of their next scheduled shift. 2. Ensure proper cleaning: Each person will have a cleaning duty list that will be signed off on and handed in prior to the end of shift to be viewed be supervisor. For completion and approval. 3. Ensure proper storage of prepared foods: Continued training and conducting in-service of how-to properly cover and store prepared food items for safe food storage will be completed by 4/30/2025 or at the start of their next scheduled shift.		

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F 812	Continued From page 38 -walk in refrigerator; one large metal pan of fruit crisp, and a tray of fruit cups were covered and not dated. DM-A indicated they should have been dated and applied dated stickers to each item. -stainless steel cupboards had smears, spots and fingerprints inside and outside the doors. The stainless-steel counter below and across the Robot Coupe on the counter multiple various size crumbs were noted. DM-A indicated they did not use the Robot Coupe at this time. -Elm/Island Pantry kitchenette fridge had some multiple irregular shaped spills and crumbs. It also had a sandwich in clear bags dated 3/24, and a clear plastic container covered with clear wrap unmarked dated 1/22. DM-A indicated he thought the container held Caesar dressing, and thought the date marked was the date it was opened and stated he would get rid of that, and DM-A put the sandwich marked 3/24 in the garbage. DM-A stated items should not be kept more than three days. -Elm kitchenette refrigerator had multiple irregular shaped spills and crumbs on shelves and bottom front area inside covering a few inches. One container of Boost supplement opened and not dated. Ten small dishes with pistachio pudding, uncovered and undated. DM-A confirmed the Boost should have been dated when opened, and the puddings should have been covered and dated. DM-A confirmed the above findings and indicated his expectation was for refrigerators to be cleaned daily or at least every other day. -Lake kitchenette refrigerator had a few irregular shaped thick sticky spills and crumbs on top shelf and spills and crumbs on the bottom front area	F 812	4. Cleaning of the kitchen and kitchenettes will be completed by 5/5/2025 including removing any expired or opened/unlabeled food. 5. An audit will be conducted by the Dietary Manager 2x/month for 3 months to monitor the ongoing food handling and cleaning procedures with in the community to ensure ongoing compliance. Results of these audits will be reviewed at QAPI.		

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F 812	Continued From page 39 inside. One sandwich in bag undated, a tomato slice in a small sandwich bag with a large amount of pink liquid dated 3/27, and a small sandwich bag of lettuce undated. In addition, a clear plastic container of butter, with written instructions on container to discard 3/24, and an undated, approximately one-half pound of butter, loosely wrapped in its paper wrapping. DM-A threw all items away. DM-A indicated he was working on getting dietary staff trained, and had a meeting scheduled 4/8/25. During a follow up interview on 4/1/25 at 3:33 p.m., DM-A confirmed the above findings. The stainless-steel cupboards in the kitchen had been cleaned on the outside, but DM-A confirmed they still were not cleaned on the inside, as spots, smears and fingerprints remained. DM-A indicated they should all be wiped down, as well as the refrigerators. DM-A was unable to locate a cleaning schedule for the main kitchen but located a handwritten cleaning schedule for the kitchenettes. DM-A stated it was important to keep the kitchen clean for the integrity of the food and not to invite rodents or pests. DM-A indicated it was important to date foods and to throw items as needed so they were not serving foods that could cause foodborne illness to the residents. Review of the facility policy titled Food Dating And Storage, undated, noted it was to ensure the service of safe potentially hazardous foods/ times and temperatures control for food and safety. The policy instructions included the following: -cover with non-absorbent lid or material, use of zip lock baggies or seal food containers. -date the food product the day put into container. -discard any unused food after five days. -food service director or cook in charge will			F 812			

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F 812	Continued From page 40 dispose of food after five days. -condiments in such as dressing, mayo, and frosting have a 30 day shelved life when stored in original containers. -Foods that do not have to be disposed of in five days are foods that have "use by", Best by" or "sell by" date located on food products. -always check packages for instructions on when to discard. If different from above, follow package guidelines.			F 812			
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include,			F 880			4/30/25

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F 880	Continued From page 41 but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.	F 880			

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F 880	Continued From page 42 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate personal protective equipment (PPE) was worn to prevent the spread of infection for for 1 of 4 residents (R25) observed for enhanced barrier precautions (EBP), (an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities). In addition, the facility failed to ensure safe delivery of beverages during the dining observation. This deficient practice had the potential to affect all 32 residents who resided in the facility. Findings Include: PPE: Review of Centers for Disease Control (CDC) guidance dated 4/1/24, Implementation of PPE Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) indicated Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions (EBP) included: Dressing, Bathing/showering, Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator and wound care: any skin opening requiring a dressing. R25's annual Minimum Data Set (MDS) dated 1/24/25, identified R25 had intact cognition with diagnoses of dystonia (movement disorder characterized by uncontrollable muscle			F 880	1. R25s care plan was reviewed ensuring it reflects the need for Enhanced Barrier Precautions due to the presence of an indwelling urinary catheter. A sign was posted outside R25s room, and a fully stocked PPE caddy was placed at the door. 2. R25 was assessed for any signs or symptoms of infection due to improper PPE use; no adverse outcomes were identified. 3. Audit completed ensuring all residents needing EBP have appropriate signage and PPE available. 4. All dining staff and clinical staff will be re-trained by 4/30/2025 end of day or the start of their next scheduled shift regarding proper handling of food and utensils, avoiding contact with glass rims, hand hygiene protocols before and after resident contact or food service tasks. Additionally, re-education was provided to all nursing staff on enhanced barrier precautions during 4/30/2025 in service or the start of their next scheduled shift. 5. The Director of Nursing or designee will audit PPE compliance during high-contact care activities 1x/wk for 6 weeks and then monthly for 3 months. DON will also conduct hand hygiene and food service observations during 1 meal period weekly for 6 weeks then monthly for 3 months. Audit results will be reviewed during quarterly QAPI meeting. Any noncompliance will result in immediate retraining and possible disciplinary action per facility policy.		

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F 880	Continued From page 43 contractions), neurogenic bladder (nerves that control bladder function are damaged), hypertension (elevated blood pressure), urinary tract infection, anxiety, depression, chronic pain. Identified R25 was independent with bed mobility, transfers and toileting, setup help only for eating and had an indwelling catheter (a hollow, flexible tube inserted through the urethra into the bladder to drain urine into an external collection bag). R25's care plan revised on 1/28/25, identified R25 required an indwelling catheter and staff were to change catheter per physician orders. R25's care plan lacked documentation for use of EBP. R25's annual Care Area Assessment (CAA) dated 1/24/25, identified R25 required an indwelling catheter. R25's CAA lacked documentation for use of EBP. R25's physician order summary report dated 12/13/24, identified R25 had an indwelling catheter that was to be changed by the facility staff on the first Monday of each month. During an observation and interview on 4/1/25 at 9:06 a.m., nursing assistant (NA)-D was in R25's bathroom assisting R25 to get dressed for the day. NA-D washed hands, put on gloves and changed R25's overnight catheter drainage bag to a leg bag for use during the day. NA-D removed her gloves and washed hands. NA-D stated she was unaware R25 was on EBP. Surveyor had NA-D verify R25 had an EBP sign and PPE bin outside of R25's room and that a gown and gloves should have been worn during high contact cares while changing R25's catheter bag and assisting R25 to get dressed. NA-D stated the facility use of EBP was pretty new,			F 880			

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F 880	Continued From page 44 unsure of exact date, and NA-D stated she had not had much training on when to use PPE with EBP. HAND HYGIENE: During an observation on 4/1/25 at 4:41 p.m., NA-E placed a clothing protector around a resident's neck and chest area and hooked the snap at the back of the residents neck area. NA-E continued this process for two more residents and touched each residents skin while the snaps were hooked around the resident's neck. NA-E proceeded to the kitchenette area, opened the refrigerator, poured five glasses of milk or juice, picked up each glass holding the top rim and delivered the glass to a resident table. NA-E removed a water pitcher from the fridge, poured multiple glasses of water, carried three glasses at a time holding them by the top rim and placed on a table. NA-E poured three glasses of milk, held top rim of each glass and delivered to a resident table. NA-E opened a cupboard door, took out four glasses and set on counter. NA-E poured four more glasses of juice or milk, held onto top rim with her hand and delivered to a resident table. During an interview on 4/1/25 at 4:52 p.m., NA-E confirmed she placed clothing protectors on residents, touched cupboard doors, refrigerator door handle, did not wash her hands, and was unaware she was touching the top rim of the glasses during dining service. NA-E stated she had not received any training on how to handle food and utensils. NA-E stated by touching the top rim of the glasses it could pass germs to residents and they could become ill.	F 880			

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F 880	Continued From page 45 During an interview on 4/2/25 at 11:44 a.m., director of nursing (DON) verified R25 was in EBP and had an indwelling catheter. DON confirmed staff had not received EBP and PPE use training except for the information that was posted on the EBP signs on a resident door. DON verified the expectation of staff was to wear PPE gown and gloves when performing high contact cares with a resident to prevent infection and the spread of infection to other residents and staff. In addition, DON verified the expectation of staff was to hold the bottom of a glass and to not touch the top rim where a resident would place their mouth to prevent infection and the spread of germs. A facility policy titled Infection Control: Essential Principles, undated, identified transmission based precautions including: contact, droplet, airborne. The policy lacked documentation on EBP and use of PPE. A facility policy titled Hand Hygiene Policy and Procedure, undated, identified employees were to follow current Centers for Disease Control and Prevention (CDC) hand hygiene recommendations. All employees were responsible for maintaining adequate hand hygiene by adhering to specific infection control practices. Compliance with proper hand hygiene procedures before and after resident contact was an expectation of all healthcare disciplines. A facility policy titled Infection Control: Essential Principles, undated, identified hand hygiene was the single most important practice to reduce the transmission of infections in healthcare settings and was an essential element of standard precautions. In addition, the policy identified hand	F 880			

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F 880	Continued From page 46 hygiene would be completed before and after preparing food.			F 880			
F 881 SS=F	A facility policy on handling food and utensils was requested and not received. Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to establish a process for antibiotic review in order to determine appropriate indications for use of an antibiotic for 1 of 1 resident (R15) reviewed for antibiotic use. Findings include: R15's admission Minimum Data Set (MDS) dated 1/20/25, identified R15 had intact cognition with diagnoses of chronic heart failure, chronic kidney disease, atrial fibrillation. The MDS further identified R15 required supervision with setup help for activities of daily living (ADL's). R15's physician's orders and oncology notes were requested and not received. R15's medication administration record (MAR)			F 881	1. Antibiotic Stewardship Program policy reviewed/retrained with DON. 2. R 15 is no longer a resident at the facility. Audit of current resident medications for prophylactic antibiotic use to ensure documented diagnosis and indication of use will be completed with any discrepancies corrected by 4/30/2025 end of day. 3. The DON or designee will conduct, at a minimum, weekly audits of resident antibiotic medication records to ensure all antibiotics have a documented diagnosis and indication, monitor duration of therapy and recommend discontinuation or adjustment as necessary based on Loeb criteria. 4. The consultant pharmacist will conduct monthly antibiotic reviews to		5/5/25

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F 881	Continued From page 47 dated 3/2025, included the following medication but lacked diagnoses or ongoing need for use: -Bactrim DS 800-160 milligrams (mg). Give one tablet by mouth in the morning every Monday, Wednesday, Friday for due to high dose of steroids. Bactrim order initiated 1/15/25. During an interview on on 4/2/25 at 12:58 p.m., RN-B verified R15 had been receiving Bactrim DS 800-160 mg since 1/15/25 and the medication had not been reviewed for antibiotic stewardship at this time. During an interview on 4/2/25 at 1:48 p.m., pharmacy consultant (PC) stated the facility is new to work with him starting three months ago. PC verified R15 was on Bactrim DS 800-160 mg and R15 had been receiving the medication since 1/15/25. PC stated the facility had not established an antibiotic stewardship program with him yet to review antibiotics monthly during his visit. PC confirmed antibiotics would only be used as ordered by a physician and would not be used long term unless indicated. During an interview on 4/2/25 at 1:50 p.m., nurse practitioner (NP) stated Bactrim DS 800-160 mg was not identified on R15's medication list on file at the clinic. NP verified if the Bactrim order was on the current medication file it would have been reviewed at each physician visit to determine if the medication could be discontinued. NP confirmed the expectation of the facility would be to review antibiotics monthly and since R15's steroid use had been decreased over the past few months the Bactrim should have been discontinued. NP verified that was important to review and discontinue antibiotics for a resident to prevent antibiotic resistance and appropriate	F 881	ensure all antibiotics have a documented diagnosis and indication, monitor duration of therapy and recommend discontinuation or adjustment as necessary. 5. Findings from both DON and consulting pharmacist audits/reviews will be reviewed during the quarterly QAPI meeting. Any discrepancies will be addressed with immediate physician follow-up and staff retraining.		

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F 881	Continued From page 48 antibiotic use. During an interview on 4/2/25 at 2:18 p.m., director of nursing (DON) verified R15 was receiving Bactrim DS 800-160 mg three times a week since 1/15/25. DON confirmed R15 was not being monitored or reviewed for antibiotic stewardship use monthly with the pharmacist or on the facility antibiotic tracking system. The facility did not currently have an infection preventionist (IP) to track and monitor unnecessary antibiotic use. DON verified the expectation of the facility was to monitor each resident receiving antibiotics at least monthly to promote the appropriate use of antibiotics and reduce possible adverse events associated with antibiotic use. A facility policy on medication administration and unnecessary medication use was requested and not received. A facility policy titled Antibiotic Stewardship Program reviewed 2/2020, identified the policy to maintain an antibiotic stewardship program with the mission of promoting the appropriate use of antibiotics to treat infections and reduce possible adverse events associated with antibiotic use. The medical director, nursing team and consultant pharmacist would be responsible for promoting the program. The IP was responsible for overseeing the antibiotic stewardship program.	F 881			
F 882 SS=F	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP)	F 882			4/30/25

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F 882	Continued From page 49 (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the acting infection preventionist (IP) had completed specialized training in infection prevention and control. This deficient practice had the potential to affect all 32 residents residing in the facility. Findings include: During an interview on 4/1/25 at 2:22 p.m., the director of nursing (DON), stated the IP resigned on 2/1/25, and the DON and two nurse managers assumed the infection control role at that time. The DON confirmed the nurse managers and herself were not enrolled in the Centers for Disease Control (CDC) infection preventionist course or any other specialized IP training. The DON added the facility was in the process of hiring a new IP. During an interview on 4/1/25 at 2:30 p.m., RN-B verified she was new to the infection preventionist			F 882	1. As of 4/1/25, the Director of Nursing was enrolled in MDH Infection Preventionist Training Course. The assigned is expected to complete all required modules before or no later than 6/1/25. Additionally, two RN managers will be enrolled in the Infection Preventionist Training Course and will be expected to complete all required modules within 6 months. 2. DON will utilize the sister facility's certified IP to provide oversight and guidance as needed until completion of specialized training. 3. The facility's Infection Control Policy was reviewed. 4. The Administrator will monitor the training status of the designated IP (DON) every 2 weeks until full certification is obtained. 5. The DON will monitor 2x/month the training status of the RN managers once		

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F 882	Continued From page 50 role and has had no training at this time. RN-B stated the IP role was split between herself, RN-A, and DON. During an interview on 4/1/25 at 2:42 p.m., the administrator stated she was aware the facility currently had no trained infection preventionist. A facility policy titled, Infection Control Policy, revised 2/2023, included the early detection, prevention and management of infections are accomplished through effective oversight of the Infection Prevention and Control program that must include at a minimum, the following elements: To recognize and manage infections at the time of the resident's admission to the facility and throughout the stay; to follow recognized infection prevention and control practice while providing care that includes transmission based precautions and isolation; to provide program oversight including planning, organizing, implementing, operating, and monitoring; to maintain all of the elements of the program and ensuring the facility's interdisciplinary teams is involved in infection prevention and control practices; to develop and revise policies, procedures, and practices that promote consistent adherence to evidence-based infection control practices; to plan organize, implement, operate and maintain all the program elements; to define roles and responsibilities during routine implementation of practice and during unusual occurrences or times of potential risk of spread of infection or outbreak; to define and manage resident and employee health initiatives. The infection Prevention and Control Program components include the establishment of surveillance standards and frequency, the development of the education component			F 882	enrolled in the MDH Infection Preventionist Training Course to ensure completion within 6 months (1 RN manager is currently out on Maternity leave and will enroll upon her return).		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245583	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/02/2025
NAME OF PROVIDER OR SUPPLIER AUBURN HOME IN WACONIA			STREET ADDRESS, CITY, STATE, ZIP CODE 594 CHERRY DRIVE WACONIA, MN 55387		
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F 882	Continued From page 51 including the training in infection prevention and control practices that ensures compliance with facility requirements as well as State and Federal regulations.	F 882			

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2 000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 3/31/25 to 4/2/2, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

04/28/25

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed: H55838361C (MN00109241), H55831120C (MN00111230). Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000			

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2 000	Continued From page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000			
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment;	2 265			4/30/25

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2 265	Continued From page 3 D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide timely notification to a provider for change in condition related to falls for 1 of 1 resident (R23) reviewed for falls. Findings include: R23's quarterly Minimum Data Set (MDS) dated 3/7/25, identified R23 had moderately impaired cognition with diagnoses of type two diabetes with chronic kidney disease, anemia, coronary artery disease, arthritis, anxiety, difficulty in walking. Identified R23 required supervision with setup help for bed mobility, transfers, eating and limited assistance of staff for toilet use. R23's care plan dated 9/13/24, identified R23 had a mobility and self care deficit and at risk for falling related to impaired mobility, weakness, and an intellectual disorder. Staff were to monitor/document/report any changes. R23 required supervision or assist to transfer on and off toilet. R23 required supervision with transfers. Review of progress notes from 11/12/24 to 3/31/25, revealed the following: R23's progress note dated 11/12/24 at 2:27 a.m., identified R23's emergency contact was called and informed of R23's fall last night and health status. R23's progress notes lacked	2 265	Corrected		

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2 265	Continued From page 4 documentation of a fall on 11/11/24. R23's progress note dated 1/28/25 at 8:50 a.m., identified R23 was found on the floor laying next to the bed with wheelchair wheels against his back. Staff helped pick R23 up from the floor and took R23 to the bathroom. R23 slipped out of the wheelchair in front of the toilet. Staff picked R23 up and placed R23 on the toilet. R23's progress note dated 2/24/25 at 14:43 p.m., identified R23 was found on the floor in front of the toilet. Staff assisted R23 into wheelchair and then onto the toilet. A follow up note at 4:16 p.m., identified R23's guardian was updated on R23's fall. R23's progress note dated 3/31/25 at 10:18 a.m., R23 was found on the floor in the bathroom. Staff reminded R23 to use the call light before transfers, vitals obtained. R23's progress note dated 3/31/25 at 10:23 a.m., R23 again found sitting on floor in front of toilet. Vitals obtained and diabetic shoes put on for better traction. R23's progress notes lacked documentation the provider had been notified. During an interview on 4/1/25 at 11:47 a.m., licensed practical nurse (LPN)-A stated R23 had a history of falls. LPN-A stated staff were to supervise R23 with toileting and assist as needed. LPN-A stated staff were expected to report a fall, ensure the resident was safe, call provider if suspected injury, complete an incident report and update provider and representative. During an interview on 4/1/25 at 11:49 a.m., RN-B	2 265			

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2 265	Continued From page 5 confirmed staff were expected to ensure a resident was safe after a fall, complete an incident/investigation report, update provider and resident representative. A voicemail was left for R23's guardian on 4/2/25 at 2:07 p.m., with no return call. During an interview on 4/2/25 at 2:22 p.m., DON verified R23 had a history of falls. DON confirmed the provider had not been updated on the above falls for R23. DON stated expectations of staff were to ensure resident was safe and not injured after a fall, complete an incident/investigation report and update provider and resident representative. DON confirmed that was important to prevent further falls and ensure the provider and representative were notified. A facility policy titled Accident: Managing Resident Falls, reviewed 7/10/24, identified a fall was defined as an unintentional change in position coming to rest on the ground, floor, or onto the next lower surface. The policy identified a licensed nurse would be notified and evaluate the condition of the resident. Staff were to notify resident representative. Staff were to notify the provider if injury suspected or noted, head strike and on anticoagulants. The policy lacked documentation that a provider would be notified of a fall regardless of injury. SUGGESTED METHOD OF CORRECTION: The facility should create policies or review and/or revise existing policies and procedures related to notification of change in resident health status or a change of condition. The Director of Nursing (or designee) should educate or re-educate nursing staff to those policies and procedures and	2 265			

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2 265	Continued From page 6 conduct measurable audits, to verify notification to appropriate parties occurred related to a change in health status or condition. The DON or designee should bring the results of those audits to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: twenty-one (21) days.	2 265			
2 620	MN Rule 4658.0445 Subp. 4 A-N Clinical Record; Admission Information Subp. 4. Admission information. Identification information must be collected and maintained for each resident upon admission and must include, at a minimum: A. the resident's legal name and preferred name; B. previous address; C. social security number; D. gender; E. marital status; F. date and place of birth; G. date and hour of admission; H. advance directives, & Do Not Resuscitate (DNR) & Do Not Intubate (DNI) status, if any; I. name, address, and telephone number of designated relative or significant other, if any; J. name, address, and telephone number of person to be notified in an emergency; legal representative, designated representative, or representative payee, if any; K. legal representative, designated representative, or representative payee, if any; L. religious affiliation, place of worship, and clergy member;	2 620		4/30/25	

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2 620	Continued From page 7 M. hospital preference; and N. name of attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure resident advance directives were accurately documented to reflect the resident's current wishes which affected 1 of 16 residents (R29) reviewed for advanced directives. This deficient practice resulted in an immediate jeopardy (IJ) for R29 who would have received cardiopulmonary resuscitation (CPR), contrary to their wishes, in the absence of a pulse or respirations. The IJ began on 1/9/25, when R29's updated physician's order for life sustaining treatment (POLST) signed on 1/9/25, identified R29's wishes of do not resuscitate (DNR). The three ring household binder and staff report form identified R29's wishes of CPR. The administrator and director of nursing (DON) were notified of the IJ on 4/1/25, at 3:35 p.m. The IJ was removed on 4/2/25, at 12:33 p.m., when the facility had implemented corrective action, however non-compliance remained at the lower scope and severity level of D, isolated with no actual harm but potential to cause more than minimal harm. Findings include: R29's quarterly Minimum Data Set (MDS) dated 3/14/25, identified R29 had moderately impaired cognition and had diagnoses which included atrial fibrillation (irregular heart rhythm), anemia, coronary artery disease (narrowing or blockage of	2 620	corrected		

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2 620	Continued From page 8 the coronary arteries). R29 was dependent on staff for activities of daily living (ADLs) which included bed mobility, toileting, and transfers. R29's current POLST signed by family member (FM)-A on 1/9/25, identified R29's wishes were DNR. The POLST was scanned into his EHR and signed by his medical provider on 1/9/25. Review of R29's electronic health record (EHR) on 3/31/25 at 5:29 p.m., identified R9 wanted DNR. R29's care plan lacked documentation on resuscitation status. Review of a facility report form undated, located at the nurses station and carried by each nurse and nursing assistant identified R29 wanted CPR. Review of the household three ring binder located at the nurses station identified R29's POLST signed 6/11/24, R29 wanted CPR. During an interview on 3/31/25 at 6:31 p.m., FM-A stated he had signed the POLST on 1/9/25, identifying that R29's wishes were to be DNR. During an interview on 3/31/25 at 7:08 p.m., registered nurse (RN)-A indicated in the event a resident did not have a pulse or respirations, she would refer to the report form and would have proceeded accordingly. During an interview on 4/1/25 at 11:47 a.m., licensed practical nurse (LPN)-A indicated in the event a resident did not have a pulse or respirations, she would refer to the report form located in her pocket and would have proceeded accordingly. LPN-A verified R29's report sheet	2 620			

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2 620	Continued From page 9 identified R29 wanted CPR. During an interview on 4/1/25 at 11:49 a.m., RN-B indicated in the event a resident did not have a pulse or respirations, she would refer to the three ring binder at the nurses desk and would have proceeded accordingly. RN-B verified R29's POLST in the binder identified R29 wanted CPR. RN-B verified there was a discrepancy between R29's EHR and the POLST in the binder and report form. During an interview on 4/1/25 at 12:18 p.m., RN-C indicated in the event a resident did not have a pulse or respirations, she would refer to the three ring binder at the nurses desk and would have proceeded accordingly. RN-C verified R29's POLST in the binder identified R29 wanted CPR. RN-C verified there was a discrepancy between R29's EHR and the POLST in the binder and report form. During a interview on 4/1/25 at 2:15 p.m., DON stated a POLST was completed with all residents or resident representatives upon admission and was effective upon admission. DON confirmed there was a discrepancy with R29's EHR, the report form and three ring binder which identified R29 was a full code and did not match his current wishes of being DNR. DON confirmed in the event R29 did not have a pulse or respirations, CPR would have been initiated against R29's wishes. DON indicated she would expect staff to follow the POLST, resident wishes and the facility policy. Review of a facility policy titled Code Status Policy and Procedure, undated, identified the facility would follow a policy regarding a resident's right to request, refuse, and/or discontinue	2 620			

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2 620	Continued From page 10 medical treatment and to formulate an advance directive. Identified the POLST would have been documented in the EHR and the household three ring binder. Further identified the code status would have been reviewed with Care Conferences at least quarterly and documented in the medical record. The IJ was removed on 4/2/25 at 12:33 p.m., when the facility developed and implemented a systemic removal plan which was verified by interview and document review: -All residents' records were reviewed to ensure the POLST form and the electronic health records were updated to ensure resident's wishes for advance directives, were accurate on 4/2/25. -R29's three ring binder was updated to match the current POLST and the code status for all residents was removed from the report form. -All current licensed staff were educated on the policy for advance directives, updating the POLST, the EHR, and the three ring binder to reflect the resident's wishes on 4/2/25, as evidenced by the education sent to all nursing staff via email on 4/2/25 and interviews. -A process was implemented to assure all other nursing staff completed mandatory education prior to the start of their next shift on 4/2/25, by notification of required education via phone/text. All staff would sign off once education had been completed. -The advance directive policy was reviewed and determined no changes were required. SUGGESTED METHOD OF CORRECTION:	2 620			

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2 620	Continued From page 11 The director of nursing (DON) or designee should review policies and procedures for advanced directives, physician orders and/or a POLST to ensure records are consistent and maintained accurate throughout the medical record upon admission, quarterly, and with any significant change such as the election of a hospice benefit. The DON should also ensure a process for inputting this changed data appropriately into the electronic medical record. Staff should be educated on the need to clarify discrepancies in advanced directives, POLST, and/or physician orders. The DON or designee should review the resident affected, and all other current residents to ensure accuracy of code status and audit any newly admitted resident EMR. The results of those audits should go to the Quality Assurance Performance Improvement (QAPI) committee for a specific time until compliance is achieved and maintained to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty One (21) days	2 620			
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.	2 830		4/30/25	

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2 830	Continued From page 12 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a comprehensive assessment (fall scene investigation) and a review or adjustment of the current fall prevention interventions to prevent falls for 1 of 1 residents (R23) who had multiple falls within the facility reviewed for falls. Findings include: R23's quarterly Minimum Data Set (MDS) dated 3/7/25, identified R23 had moderately impaired cognition with diagnoses of type two diabetes with chronic kidney disease, anemia, coronary artery disease, arthritis, anxiety, difficulty in walking. Identified R23 required supervision with setup help for bed mobility, transfers, eating and limited assistance of staff for toilet use. R23's care plan dated 9/13/24, identified R23 had a mobility and self care deficit and at risk for falling related to impaired mobility, weakness, history of falls, and an intellectual disorder. R23 required supervision or assist to transfer on and off toilet. R23 required supervision with transfers. Staff were to monitor/document/report any changes. Review of R23's progress notes from 11/12/24 to 3/31/25, revealed the following: -On 11/7/24 at 8:31 a.m., identified R23 was found on the floor in the bathroom. R23 was reminded to use the call light and wait for	2 830	Corrected		

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2 830	Continued From page 13 assistance. The progress note lacked a fall scene investigation to evaluate the root cause of the fall and implement or change interventions on the plan of care. -On 11/12/24 at 2:27 p.m., identified R23's emergency contact was called and informed of R23's fall last night and health status. R23's progress notes lack documentation of a fall on 11/11/24 and a fall scene investigation to evaluate the root cause of the fall and implement or change interventions on the plan of care. -On 12/17/24 at 6:30 a.m., identified R23 stated he hit his head on the bathroom wall while self transferring from toilet to wheelchair. R23 was sent to the emergency department for evaluation. A follow up progress note on 12/17/24 at 12:03 p.m., identified R23 returned from the emergency department and presented with his usual mental and physical abilities. R23 had a contusion on the left knee and pain in the right hip, received Tylenol. No contusion present on R23's head. The progress note lacked a fall scene investigation to evaluate the root cause of the fall and implement or change interventions on the plan of care. -On 1/5/25 at 5:30 a.m., identified R23 was found on the floor next to the bed. R23 was assisted into the wheelchair and confirmed no injuries. The progress note lacked a fall scene investigation to evaluate the root cause of the fall and implement or change interventions on the plan of care. -On 1/27/25 at 7:04 p.m., identified R23 was on the floor with no injury noted. Staff reminded R23 to call for assistance. The progress note lacked a fall scene investigation to evaluate the root cause of the fall and implement or change interventions	2 830			

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2 830	Continued From page 14 on the plan of care. -On 1/28/25 at 8:50 a.m., identified R23 was found on the floor laying next to the bed with wheelchair wheels against his back. Staff helped pick R23 up from the floor and took R23 to the bathroom. R23 then slipped out of the wheelchair in front of the toilet. Staff picked R23 up and placed R23 on the toilet. The progress note lacked a fall scene investigation to evaluate the root cause of the fall and implement or change interventions on the plan of care. -On 2/24/25 at 14:43 p.m., identified R23 was found on the floor in front of the toilet. Staff assisted R23 into wheelchair and then onto the toilet. The progress note lacked a fall scene investigation to evaluate the root cause of the fall and implement or change interventions on the plan of care. -On 3/6/25 at 14:40 p.m., identified R23 fell in the bathroom for the second time. After the second fall R23 stated his right knee hurt. The progress notes lacked documentation of a first fall on 3/6/25 and further lacked a fall scene investigation to evaluate the root cause of both falls and implement or change interventions on the plan of care. -On 3/31/25 at 10:18 a.m., R23 was found on the floor in the bathroom. Staff reminded R23 to use the call light before transfers, vitals obtained. The progress note lacked a fall scene investigation to evaluate the root cause of the fall and implement or change interventions on the plan of care. -On 3/31/25 at 10:23 a.m., R23 again found sitting on floor in front of toilet. Vitals obtained and diabetic shoes put on for better traction. The	2 830			

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2 830	Continued From page 15 progress note lacked a fall scene investigation to evaluate the root cause of the fall. During an interview on 4/1/25 at 11:47 a.m., licensed practical nurse (LPN)-A stated R23 had a history of falls. LPN-A stated staff were to supervise R23 with toileting and assist as needed. LPN-A stated a falls assessment would be completed and an intervention put in place. During an interview on 4/1/25 at 11:49 a.m., RN-B confirmed the above falls occurred for R23. RN-B verified a falls assessment identified as a fall scene investigation was to be completed after each fall to identify the root cause of the fall and an intervention would be implemented on the care plan to prevent further falls. RN-B confirmed a fall scene investigation and new care plan interventions were not completed for the above falls. During an interview on 4/2/25 at 11:51 a.m., physical therapist (PT) verified R23 was receiving therapy for strengthening and falls. PT stated therapy was working with R23 on standing tolerance as R23 had many falls in the bathroom. PT confirmed R23 was not to be independent in the bathroom and to have staff assistance. During an interview on 4/2/25 at 2:22 p.m., DON verified R23 had a history of falls and verified the above falls occurred. DON confirmed a fall scene investigation and care plan interventions were not completed for the above falls. DON stated expectations of staff were to ensure resident was safe and not injured after a fall, complete a falls scene investigation to evaluate and implement or change interventions on the plan of care. DON confirmed that was important to prevent further falls and injury.	2 830			

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2 830	Continued From page 16 A facility policy titled Accident: Managing Resident Falls, reviewed 7/10/24, identified a fall was defined as an unintentional change in position coming to rest on the ground, floor, or onto the next lower surface. The policy identified a licensed nurse would be notified and evaluate the condition of the resident. The staff in conjunction with the interdisciplinary team (IDT), resident and or resident representative would implement the residents plan of care with interventions to reduce the risk of falls. Following a fall, staff would initiate a fall scene investigation to evaluate and implement or change interventions on the plan of care to minimize serious consequences of falling. Immediate interventions implemented or changed to prevent additional falls must be documented on the fall scene investigation form. IDT would review all falls and interventions implemented to further reduce the risk of additional falls. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventions are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830			
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the	2 920			4/30/25

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2 920	Continued From page 17 comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide assistance with routine grooming care which included facial hair removal for 3 of 3 residents (R7, R12, R3) reviewed for activities of daily living (ADLs) who required assistance with grooming and personal hygiene. Findings include: R7 R7's quarterly Minimum Data Set (MDS) dated 3/31/25, identified R7 as being cognitively intact, and diagnoses which included heart failure, asthma, macular degeneration (vision loss), and dysphagia (difficulty swallowing). R7 required moderate assistance for personal hygiene which included washing and drying face, shaving, and combing hair. R7's care plan revised on 11/4/24, identified R7 requires moderate assistance with personal hygiene. During an observation on 3/31/25 at 4:28 p.m., R7 had .25 centimeters (cm) of hair growth on the cheeks, chin, neck, and upper lips. During an observation on 4/1/25 at 8:11 a.m., R7	2 920	Corrected		

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2 920	Continued From page 18 was sitting at the breakfast table and continued to have 0.25 cm of hair growth on their face and neck. During an observation on 4/1/25 at 3:50 p.m., R7 was sitting in his room and continued to have 0.25 cm of hair growth on his face and neck. During an interview on 3/31/25 at 4:28 p.m., R7 stated that he would like to be shaved daily. During an interview on 4/1/25 at 4:00 p.m., nursing assistant (NA)-A indicated he was unsure how often R7 would like to be shaved. NA-A reported it was his second shift at the facility and was unaware of how often residents were to be shaved but would assume it would be on a resident's bath day. During an interview on 4/2/25 at 7:18 a.m., NA-B indicated she was unaware of how often R7 would like to be shaved. NA-B indicated residents should have been offered to be shaved on their bath day. NA-B reported it was her first shift at the facility. During an interview on 4/2/25 at 8:01 a.m., NA-C indicated R7 needed assistance with ADLs. NA-C reported R7 was shaved on his bath day and would need to request if he wants to be shaved in addition to once a week. During an interview on 4/1/25 at 4:11 p.m., registered nurse (RN)-A indicated it was her expectation residents were shaved every morning. RN-A verified that R7 had facial hair and should have been offered assistance with grooming. R12	2 920			

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2 920	Continued From page 19 R12's significant change MDS dated 4/4/25, identified R12 as severely cognitively impaired with diagnoses which included dementia, muscle weakness, and peripheral vascular disease (a progressive disorder of the blood vessels). Identified R12 required maximal assistance for personal hygiene which included washing their face, shaving, and combing their hair. R12's care plan revised on 10/11/24, identified R12 required physical assistance with ADLS and mobility on more than a daily basis. During an observation on 3/31/25 at 4:40 p.m., R12 had one cm of hair growth on the face, upper lip, cheeks, and neck. During an observation on 4/1/25 at 8:11 a.m., R12 was sitting at the breakfast table dressed. R12 had not been shaved and continued to have one cm of facial hair on the face and neck. During an observation on 4/1/25 at 3:49 p.m., R12 was in his room and continued to have one cm of facial hair on his face and neck. During an interview on 3/31/25 at 4:40 p.m., R12 indicated he would like to be shaved daily. During an interview on 4/1/25 at 4:00 p.m., nursing assistant (NA)-A indicated he was unaware of how often R12 liked to be shaved. NA-A reported it was his second shift at the facility and was unaware of how often residents were to be shaved but would assume it would be on a resident's bath day. During an interview on 4/2/25 at 7:18 a.m., NA-B indicated she was unaware of how often R12	2 920			

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2 920	Continued From page 20 would like to be shaved. NA-B indicated residents should have been offered the resident's bath day once a week. NA-B reported it was her first shift at the facility. During an interview on 4/1/25 at 4:11 p.m., RN-A indicated it was her expectation residents were shaved every morning. RN-A went into R12's room and verified that R12 had facial hair around one cm. long. R12 told RN-A he wanted his beard shaved today. During an interview on 4/2/25 at 8:01 a.m., NA-C indicated R12 required assistance with ADLs and was shaved on his bath day. R3 R3 admission MDS dated 2/17/25, identified R3 as severely cognitively impaired with a diagnosis that included Parkinson ' s (brain disorder that causes problems with movement, balance, and coordination), dementia, and diabetes (a disease that affects how the body uses blood sugars). Identified R3 as being on hospice and needing supervision or touching assistance for combing hair, shaving, washing face and hands. R3 care plan revised on 2/19/25, identified R3 required supervision or touching assistance for personal care. During an observation on 3/31/25 at 3:00 p.m., R3 was sleeping in his room and noted to have two cm of facial hair on cheeks, chin, and neck. During an observation on 4/1/25 at 8:13 a.m., R3 was sitting at the breakfast table sleeping. R3 was dressed and continued to have two cm length of facial hair on face and neck.	2 920			

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2 920	Continued From page 21 During an observation on 4/1/25 at 3:27 p.m., R3 was sitting in his bedroom in his wheelchair sleeping. R3 continued to have two cm length of facial hair on the face and neck. During an interview on 3/31/25 at 3:00 p.m., with power of attorney (POA) indicated R3 would like to be shaved daily. R3 shaved daily when living at home and having facial hair would bother him. During an interview on 4/1/25 at 4:00 p.m., nursing assistant (NA)-A indicated he was unaware of how often R3 liked to be shaved. NA-A reported it was his second shift at the facility and was unaware of how often residents were to be shaved but would assume it would be on a resident's bath day. During an interview on 4/2/25 at 7:18 a.m., NA-B indicated she was unaware of how often R3 would like to be shaved. NA-B indicated residents were offered to be shaved on the resident's bath day once a week. NA-B reported it was her first shift at the facility. During an interview on 4/1/25 at 4:11 p.m., RN-A went into R3's room and verified that R12 had facial hair around two cm in length of facial hair. During an interview on 4/2/25 at 8:01 a.m., NA-C indicated R3 required assistance with ADLs and was shaved on his bath day. During an interview on 4/2/25 at 9:02 a.m., director of nursing (DON) indicated residents were shaved on their bath day which was normally once a week. DON was unaware if residents were asked what their preference was with shaving on admission. The DON was unsure	2 920			

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2 920	Continued From page 22 if their preference on how often they would like to be shaved was included in the care plan. The DON expectation would be to ask residents what their preference was for shaving and placing the resident's preference in the care plan. A policy for grooming and/or ADL care was requested and non was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to activities of daily living. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing assistance with activities of daily living. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 920			
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure food items were properly labeled and dated after packaging was opened and were disposed of after the expiration date to prevent cross contamination. In addition, the facility failed to maintain a clean and sanitary kitchen area. This deficient practice had	21015	Corrected	4/30/25	

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21015	Continued From page 23 the potential to affect all 32 residents currently residing in the facility. Findings Include: During an initial tour of the kitchen and kitchenettes on 3/31/25 at 2:10 p.m., with dietary manager (DM)-A, the following areas of concern were identified: -walk in refrigerator; one large metal pan of fruit crisp, and a tray of fruit cups were covered and not dated. DM-A indicated they should have been dated and applied dated stickers to each item. -stainless steel cupboards had smears, spots and fingerprints inside and outside the doors. The stainless-steel counter below and across the Robot Coupe on the counter multiple various size crumbs were noted. DM-A indicated they did not use the Robot Coupe at this time. -Elm/Island Pantry kitchenette fridge had some multiple irregular shaped spills and crumbs. It also had a sandwich in clear bags dated 3/24, and a clear plastic container covered with clear wrap unmarked dated 1/22. DM-A indicated he thought the container held Caesar dressing, and thought the date marked was the date it was opened and stated he would get rid of that, and DM-A put the sandwich marked 3/24 in the garbage. DM-A stated items should not be kept more than three days. -Elm kitchenette refrigerator had multiple irregular shaped spills and crumbs on shelves and bottom front area inside covering a few inches. One container of Boost supplement opened and not dated. Ten small dishes with pistachio pudding, uncovered and undated. DM-A confirmed the	21015			

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21015	Continued From page 24 Boost should have been dated when opened, and the puddings should have been covered and dated. DM-A confirmed the above findings and indicated his expectation was for refrigerators to be cleaned daily or at least every other day. -Lake kitchenette refrigerator had a few irregular shaped thick sticky spills and crumbs on top shelf and spills and crumbs on the bottom front area inside. One sandwich in bag undated, a tomato slice in a small sandwich bag with a large amount of pink liquid dated 3/27, and a small sandwich bag of lettuce undated. In addition, a clear plastic container of butter, with written instructions on container to discard 3/24, and an undated, approximately one-half pound of butter, loosely wrapped in its paper wrapping. DM-A threw all items away. DM-A indicated he was working on getting dietary staff trained, and had a meeting scheduled 4/8/25. During a follow up interview on 4/1/25 at 3:33 p.m., DM-A confirmed the above findings. The stainless-steel cupboards in the kitchen had been cleaned on the outside, but DM-A confirmed they still were not cleaned on the inside, as spots, smears and fingerprints remained. DM-A indicated they should all be wiped down, as well as the refrigerators. DM-A was unable to locate a cleaning schedule for the main kitchen but located a handwritten cleaning schedule for the kitchenettes. DM-A stated it was important to keep the kitchen clean for the integrity of the food and not to invite rodents or pests. DM-A indicated it was important to date foods and to throw items as needed so they were not serving foods that could cause foodborne illness to the residents. Review of the facility policy titled Food Dating And Storage, undated, noted it was to ensure the	21015			

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21015	Continued From page 25 service of safe potentially hazardous foods/ times and temperatures control for food and safety. The policy instructions included the following: -cover with non-absorbent lid or material, use of zip lock baggies or seal food containers. -date the food product the day put into container. -discard any unused food after five days. -food service director or cook in charge will dispose of food after five days. -condiments in such as dressing, mayo, and frosting have a 30 day shelved life when stored in original containers. -Foods that do not have to be disposed of in five days are foods that have "use by", Best by" or "sell by" date located on food products. -always check packages for instructions on when to discard. If different from above, follow package guidelines. SUGGESTED METHOD OF CORRECTION: The dietary manager, registered dietitian, or administrator, could ensure appropriate security and sanitation of food items and or equipment in the kitchen and dining areas. The facility should also ensure appropriate storage of food occurs. The facility could update or create policies and procedures and educate staff on these changes and perform competencies. The dietary manager, registered dietitian, or administrator could perform audits and report audit findings to the Quality Assurance Performance Improvement (QAPI) for further recommendations or to determine compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21015			
21385	MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance	21385			4/30/25

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
21385	Continued From page 26 Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate personal protective equipment (PPE) was worn to prevent the spread of infection for for 1 of 4 residents (R25) observed for enhanced barrier precautions (EBP), (an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities). In addition, the facility failed to ensure safe delivery of beverages during the dining observation. This deficient practice had the potential to affect all 32 residents who resided in the facility. Findings Include: PPE: Review of Centers for Disease Control (CDC) guidance dated 4/1/24, Implementation of PPE Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) indicated Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions (EBP) included: Dressing, Bathing/showering, Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting, device care or	21385	Corrected		

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21385	Continued From page 27 use: central line, urinary catheter, feeding tube, tracheostomy/ventilator and wound care: any skin opening requiring a dressing. R25's annual Minimum Data Set (MDS) dated 1/24/25, identified R25 had intact cognition with diagnoses of dystonia (movement disorder characterized by uncontrollable muscle contractions), neurogenic bladder (nerves that control bladder function are damaged), hypertension (elevated blood pressure), urinary tract infection, anxiety, depression, chronic pain. Identified R25 was independent with bed mobility, transfers and toileting, setup help only for eating and had an indwelling catheter (a hollow, flexible tube inserted through the urethra into the bladder to drain urine into an external collection bag). R25's care plan revised on 1/28/25, identified R25 required an indwelling catheter and staff were to change catheter per physician orders. R25's care plan lacked documentation for use of EBP. R25's annual Care Area Assessment (CAA) dated 1/24/25, identified R25 required an indwelling catheter. R25's CAA lacked documentation for use of EBP. R25's physician order summary report dated 12/13/24, identified R25 had an indwelling catheter that was to be changed by the facility staff on the first Monday of each month. During an observation and interview on 4/1/25 at 9:06 a.m., nursing assistant (NA)-D was in R25's bathroom assisting R25 to get dressed for the day. NA-D washed hands, put on gloves and changed R25's overnight catheter drainage bag to a leg bag for use during the day. NA-D removed her gloves and washed hands. NA-D	21385			

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21385	Continued From page 28 stated she was unaware R25 was on EBP. Surveyor had NA-D verify R25 had an EBP sign and PPE bin outside of R25's room and that a gown and gloves should have been worn during high contact cares while changing R25's catheter bag and assisting R25 to get dressed. NA-D stated the facility use of EBP was pretty new, unsure of exact date, and NA-D stated she had not had much training on when to use PPE with EBP. HAND HYGIENE: During an observation on 4/1/25 at 4:41 p.m., NA-E placed a clothing protector around a resident's neck and chest area and hooked the snap at the back of the residents neck area. NA-E continued this process for two more residents and touched each residents skin while the snaps were hooked around the resident's neck. NA-E proceeded to the kitchenette area, opened the refrigerator, poured five glasses of milk or juice, picked up each glass holding the top rim and delivered the glass to a resident table. NA-E removed a water pitcher from the fridge, poured multiple glasses of water, carried three glasses at a time holding them by the top rim and placed on a table. NA-E poured three glasses of milk, held top rim of each glass and delivered to a resident table. NA-E opened a cupboard door, took out four glasses and set on counter. NA-E poured four more glasses of juice or milk, held onto top rim with her hand and delivered to a resident table. During an interview on 4/1/25 at 4:52 p.m., NA-E confirmed she placed clothing protectors on residents, touched cupboard doors, refrigerator door handle, did not wash her hands, and was unaware she was touching the top rim of the	21385			

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21385	Continued From page 29 glasses during dining service. NA-E stated she had not received any training on how to handle food and utensils. NA-E stated by touching the top rim of the glasses it could pass germs to residents and they could become ill. During an interview on 4/2/25 at 11:44 a.m., director of nursing (DON) verified R25 was in EBP and had an indwelling catheter. DON confirmed staff had not received EBP and PPE use training except for the information that was posted on the EBP signs on a resident door. DON verified the expectation of staff was to wear PPE gown and gloves when performing high contact cares with a resident to prevent infection and the spread of infection to other residents and staff. In addition, DON verified the expectation of staff was to hold the bottom of a glass and to not touch the top rim where a resident would place their mouth to prevent infection and the spread of germs. A facility policy titled Infection Control: Essential Principles, undated, identified transmission based precautions including: contact, droplet, airborne. The policy lacked documentation on EBP and use of PPE. A facility policy titled Hand Hygiene Policy and Procedure, undated, identified employees were to follow current Centers for Disease Control and Prevention (CDC) hand hygiene recommendations. All employees were responsible for maintaining adequate hand hygiene by adhering to specific infection control practices. Compliance with proper hand hygiene procedures before and after resident contact was an expectation of all healthcare disciplines. A facility policy titled Infection Control: Essential	21385			

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21385	Continued From page 30 Principles, undated, identified hand hygiene was the single most important practice to reduce the transmission of infections in healthcare settings and was an essential element of standard precautions. In addition, the policy identified hand hygiene would be completed before and after preparing food. A facility policy on handling food and utensils was requested and not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure infection control procedures and standards, and when to use EBP. The DON or designee could educate all appropriate staff on the policies/procedures, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days.	21385			
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the	21540			4/30/25

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21540	Continued From page 31 medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to identify diagnoses or indications for use of medications for 1 of 6 residents (R15) reviewed for unnecessary medications. Findings include: R15's admission Minimum Data Set (MDS) dated 1/20/25, identified R15 had intact cognition with diagnoses of chronic heart failure, chronic kidney disease, atrial fibrillation. Identified R15 required supervision with setup help for activities of daily living (ADL's). R15's physician's orders and oncology notes were requested and not received. R15's medication administration record (MAR) dated 3/2025, included the following medication but lacked diagnoses or ongoing need for use: -Bactrim DS 800-160 milligrams (mg). Give one tablet by mouth in the morning every Monday, Wednesday, Friday for due to high dose of steroids. Bactrim order initiated 1/15/25.	21540	Corrected		

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21540	Continued From page 32 During an interview on on 4/2/25 at 12:58 p.m., RN-B verified R15 had been receiving Bactrim DS 800-160 mg since 1/15/25, and the medication had not been reviewed for unnecessary medications at this time. During an interview on 4/2/25 at 1:48 p.m., pharmacy consultant (PC) stated the facility starting working with the facility three months ago. PC verified R15 was on Bactrim DS 800-160 mg and R15 had been receiving the medication since 1/15/25. PC stated the facility had not established an antibiotic stewardship program with him yet to review antibiotics monthly during his visit. PC confirmed antibiotics would only be used as ordered by a physician and would not be used long term unless indicated. During an interview on 4/2/25 at 1:50 p.m., nurse practitioner (NP) stated Bactrim DS 800-160 mg was not identified on R15's medication list on file at the clinic. NP verified if the Bactrim order was on the current medication file it would have been reviewed at each physician visit to determine if the medication could be discontinued. NP confirmed the expectation of the facility would be to review antibiotics monthly and since R15's steroid use had been decreased over the past few months the Bactrim should have been discontinued. NP verified that was important to review and discontinue unnecessary medications for a resident to prevent unnecessary medication use. During an interview on 4/2/25 at 2:18 p.m., director of nursing (DON) verified R15 was receiving Bactrim DS 800-160 mg three times a week since 1/15/25. DON confirmed R15 was not being monitored or reviewed for unnecessary medication use monthly with the pharmacist or on	21540			

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21540	Continued From page 33 the facility antibiotic tracking system. The facility did not currently have an infection preventionist to track and monitor unnecessary antibiotic use. DON verified the expectation of the facility was to monitor each resident for unnecessary medications at least monthly to prevent unnecessary medication use. A facility policy on medication administration and unnecessary medication use was requested and not received. A facility policy titled Antibiotic Stewardship Program reviewed 2/2020, identified the policy to maintain an antibiotic stewardship program with the mission of promoting the appropriate use of antibiotics to treat infections and reduce possible adverse events associated with antibiotic use. The medical director, nursing team and consultant pharmacist would be responsible for promoting the program. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper monitoring of medication usage. The DON or designee, along with the pharmacist, could audit medication reviews on a regular basis to ensure compliance. TIMEFRAME FOR CORRECTION: Twenty-one (21) days.	21540			
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment,	21880			4/30/25

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21880	Continued From page 34 to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure.	21880			

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21880	Continued From page 35 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure that three years of survey results and the plan of correction were readily accessible to residents or visitors. This deficient practice had the potential to affect all 32 residents currently residing in the facility. Findings include: During an observation on 4/1/25 at 12:00 p.m., the survey results binder was located on a shelf in a sitting area by the front door. The binder contained the last survey results noted from 2/29/24. The binder lacked the plan of correction for the 2/29/24, survey results. The binder lacked the survey results and plan of correction from the 12/1/22, survey. During a co-interview on 4/1/25 at 12:35 p.m., the administrator and director of nursing (DON) confirmed the most recent survey results from 2/29/24, were in the binder without the plan of correction and the plan of correction should have been included in the binder. The administrator and DON verified their process was to keep the most recent survey results in the binder and not the past three years. A policy on survey inspection results was requested and one was not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could review and revise policies pertaining to resident grievances, educate staff on these policies and perform audits to ensure postings, forms, etc. are readily available for residents and	21880	Corrected		

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21880	Continued From page 36 residents can file anonymously. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21880			

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

PRINTED: 04/28/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245583		(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - NEW BLDG B. WING _____		(X3) DATE SURVEY COMPLETED 04/03/2025	
NAME OF PROVIDER OR SUPPLIER AUBURN HOME IN WACONIA				STREET ADDRESS, CITY, STATE, ZIP CODE 594 CHERRY DRIVE WACONIA, MN 55387			
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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on April 3, 2025, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Auburn Home in Waconia, was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.			K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/28/2025

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Building Info: Auburn Home in Waconia was constructed in 2007, is one-story in height, has no basement, is fully fire sprinkler protected, and was determined to be of Type V(111) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification.	K 000			

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K 000	Continued From page 2 The facility has a capacity of 37 beds and had a census of 32 at the time of the survey.	K 000			
K 211 SS=F	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain a clear path of egress system per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.1 and 7.1.10.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/03/2025 between 9:00 AM and 11:30 AM, it was revealed by observation that there were items being stored within the egress corridor outside of the Kitchen. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 211		4/30/25	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101	K 345	1. The egress corridor outside the kitchen has been cleared of all obstructions. 2. The Dietary Manager, Housekeeping Manager, DON and Scheduler have been retrained on need to keep egress corridor outside the kitchen free of all obstructions via email on 4/21/2025. 3. All nursing (nurse manager, nurses, TMAs and CNAs) and dietary staff will be retrained on need to keep egress corridors free of obstructions by the end of the day 4/30/2025 or the start of their next scheduled shift. 4. Ongoing compliance will be monitored by the Facilities Director via random audit of 2 corridors/month for 3 months	4/30/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245583	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - NEW BLDG B. WING _____		(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER AUBURN HOME IN WACONIA			STREET ADDRESS, CITY, STATE, ZIP CODE 594 CHERRY DRIVE WACONIA, MN 55387		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 345	Continued From page 3 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.4.1 and 9.6.1.5, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, sections 14.4.5.3.2, and 14.6.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 04/03/2025 between 9:00 AM and 11:30 AM, it was revealed by a review of available documentation that only 2 of 3 sprinkler supervisory switches and 1 of 3 door holds were tested on the report dated 04/16/2024. An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K 345			
K 351 SS=F	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING	K 351	1. IFS emailed explanation for discrepancies from previous report. This was sent to the Fire Marshall and attached to last years report. 2. Ongoing monitoring will be done by the Facilities Director by reviewing annual reports for any discrepancies and obtaining required explanation for any discrepancies. Any explanations for report discrepancies will be attached to the report and stored together.		4/30/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245583		(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - NEW BLDG B. WING _____		(X3) DATE SURVEY COMPLETED 04/03/2025	
NAME OF PROVIDER OR SUPPLIER AUBURN HOME IN WACONIA				STREET ADDRESS, CITY, STATE, ZIP CODE 594 CHERRY DRIVE WACONIA, MN 55387			
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K 351	Continued From page 4 Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install sprinkler heads per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.1 and 9.7.1.1 and NFPA 13 (2010 edition), The Standard for the Installation of Sprinkler Systems, sections 8.1.1, 8.3.2.5, 8.4.9.1 and 8.4.9.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/03/2025 between 9:00 AM and 11:30 AM, it was revealed by observation that there was a cold water line resting on the sprinkler system above the ceiling outside of the Kitchen. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K 351	1. Cold Water line resting on the sprinkler system has been secured to ensure it no longer touches the sprinkler system pipe. 2. Ongoing monitoring for compliance will be completed by the Facilities Director by conducting random audits of the sprinkler pipes 2x/month for 3 months.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245583	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - NEW BLDG B. WING _____		(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER AUBURN HOME IN WACONIA			STREET ADDRESS, CITY, STATE, ZIP CODE 594 CHERRY DRIVE WACONIA, MN 55387		
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K 363 SS=F	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.	K 363		4/30/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245583	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - NEW BLDG B. WING _____		(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER AUBURN HOME IN WACONIA			STREET ADDRESS, CITY, STATE, ZIP CODE 594 CHERRY DRIVE WACONIA, MN 55387		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 363	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/03/2025 , between 9:00 AM and 11:30 AM, it was revealed by observation that the fire doors leading into the Island Household failed to latch when tested. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 363	1. Corridor door leading into Island Household fixed to latch correctly. 2. Ongoing monitoring will be conducted by the Facilities Director by completing a random audit of 2 corridor doors/month for 3 months.		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

NOTICE OF TOTAL AMOUNT OF ASSESSMENT
FOR NURSING HOMES

June 23, 2025

Administrator
Auburn Home In Waconia
594 Cherry Drive
Waconia, MN 55387

RE: ZHJ113

Dear Administrator:

On June 23, 2025, a Notice of Assessment for Noncompliance with Correction Orders with an imposed a daily fine in the amount of \$350 was electronically issued to the above facility. An acknowledgement was electronically received by the Department stating that the violation(s) had been corrected. A reinspection was held on June 23, 2025 and it was determined that compliance with the licensing rules was attained.

Therefore, the total amount of the assessment is \$350. In accordance with Minnesota Statutes, § 144A.10, subdivision 7, the costs of the reinspection, totaling \$29, are to be added to the total amount of the assessment. You are required to submit a check, made payable to the Minnesota Department of Health in the amount of \$379 within 15 days of the receipt of this notice.

Please send a copy of this letter and the check to:

Department of Health
Health Regulation Division,
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Sincerely,

A handwritten signature in cursive script that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

cc: Shellae Dietrich, Program Assurance Superviosr
Kami Fiske-Downing, Licensing and Certification Program

