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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: CU72

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00335

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245604**

2.STATE VENDOR OR MEDICAID NO.
(L2) **422243100**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/14/2019** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **61** (L18)
13.Total Certified Beds **61** (L17)

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date:
Susanne Reuss, Unit Supervisor 01/23/2019 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Douglas Larson, Enforcement Specialist 01/23/2019 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/14/2019
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 23, 2019

Administrator
Auburn Manor
501 Oak Street
Chaska, MN 55318

RE: Project Number S5604030

Dear Administrator:

On December 12, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 5, 2018. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On January 14, 2019, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on January 22, 2019 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 5, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 14, 2019. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 5, 2018, effective January 14, 2019 and therefore remedies outlined in our letter to you dated December 12, 2018, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit

Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

CMS Certification Number (CCN): 245604

January 23, 2019

Administrator
Auburn Manor
501 Oak Street
Chaska, MN 55318

Dear Administrator:

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

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

Effective January 14, 2019 the above facility is certified for:

61 Skilled Nursing Facility/Nursing Facility Beds

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

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

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

Please contact me if you have any questions.

Sincerely,

Douglas Larson, Enforcement Specialist

Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: CU72

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1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/05/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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From (a) :
To (b) :

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Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE — Date:
Lou Anne Page, HFE NE II — 12/28/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Douglas Larson, Enforcement Specialist — 01/14/2019 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
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22. ORIGINAL DATE OF PARTICIPATION
08/01/1992
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
December 12, 2018

Administrator
Auburn Manor
501 Oak Street
Chaska, MN 55318

RE: Project Number S5604030, H5604028

Dear Administrator:

On December 5, 2018, a standard survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required. In addition, at the time of the December 5, 2018 standard survey, the Minnesota Department of Health completed an investigation of complaint number H5604028 that was found to be unsubstantiated.

OPPORTUNITY TO CORRECT - DATE OF CORRECTION

The date by which the deficiencies must be corrected to avoid imposition of remedies is January 14, 2019.

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.

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.

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

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

- Discretionary denial of payment for new Medicare and Medicaid admissions (42 CFR 88.417 (a));

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

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Eva Loch, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: eva.loch@state.mn.us
Phone: (651) 201-3792
Fax: (651) 215-9697

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 the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by March 5, 2019 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by June 5, 2019 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

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

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. BUILDING _____ B. WING _____	12/05/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements was conducted on 12/3/18, through 12/5/18, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS A recertification survey was conducted 12/3/18, through 12/5/18, and a complaint investigation was also completed at the time of the standard survey. At the time of the survey, an investigation of complaint H5604028 was completed and was found to be unsubstantiated. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent	F 686		1/14/19

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

Electronically Signed | 12/21/2018

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. BUILDING _____ B. WING _____	12/05/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 1 pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to reposition 1 or 2 residents (R8) with pressure ulcers according to their care plan. Findings include: R8's Face Sheet indicated R8 was admitted to the facility 6/15/15, with diagnoses of diabetes mellitus, stasis dermatitis, and chronic obstructive pulmonary disease. R8's Resident Progress Notes dated 8/30/18, indicated R8 had developed a pressure ulcer on the right side of his coccyx. R8's Progress Notes dated 10/2/18, indicated the wound on the right coccyx had healed. R8's Progress Notes dated 11/13/18, indicated the coccyx wound had reopened. R8's care plan last reviewed 11/6/18, indicated R8 was supposed to be repositioned every two hours and as needed. On 12/4/18, at 5:04 p.m. a continuous observation of R8 began. R8 was sitting in a wheelchair in his room watching TV. At 5:11 p.m. a staff member pushed R8 in his wheelchair to the dining room. R8 remained in the dining room sitting in his wheelchair until 5:58 p.m. At 5:58 p.m. staff pushed R8 in his wheelchair to his room. R8 was observed from 5:58 p.m. until 7:22 p.m. sitting in a wheelchair in his room watching	F 686	It is the policy, and intention, of Auburn Manor to be in full compliance with all regulations and requirements of both the Medicaid and Medicare programs. These plans and responses to the findings are written solely to maintain certification in the Medicare and Medicaid Programs and, as required, are submitted as the facility□s CREDIBLE ALLEGATION OF COMPLIANCE. This written response does not constitute an admission of noncompliance with any requirement. Submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. We wish to preserve our right to dispute these findings in their entirety should any remedies be imposed. It is the intention of Auburn Manor to be compliant with the requirements at F 686. The facility provides treatment and services to prevent and heal pressure ulcers. During the standard survey, one surveyor observed one resident's repositioning interval to exceed the care planned repositioning schedule. The resident did not have an open area at the time of the survey.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. BUILDING _____ B. WING _____	12/05/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 2 TV. No staff entered the room during that time. At 7:22 p.m. nursing assist (NA)- A entered R8's room and administered medications. From 7:22 p.m. until 7:29 p.m. NA-A assisted R8 with medications. R8 remained sitting in his wheelchair during that time. At 7:29 p.m. NA-A exited R8's room and was asked how often R8 was supposed to be repositioned. NA-A stated every two hours. When asked how long it had been since R8 was repositioned. NA-A stated since about 4:00 p.m., but added she was not being sure of the exact time. The continuous observation ended at 7:29 p.m. On 12/4/18, at 7:33 p.m. a licensed practical nurse (LPN)-A was asked how often R8 was supposed to be repositioned. LPN-A stated every two hours. LPN-A stated she thought he was repositioned at about 5:00 p.m., but was unsure of the time. LPN-A requested assistance from staff and went to R8's room. R8 was assisted into the sit to stand lift and was transferred to the bathroom to use the toilet. LPN-A re-assessed R8's skin. It was observed that R8 had been incontinent and had feces on his incontinence brief and buttocks. On 12/5/18, at 1:10 p.m. during an interview the director of nursing (DON) stated the system for knowing when to reposition a resident was verbally in report or by documenting on the computer. The DON added some NA's kept a sheet of paper with the times on it in their pocket. The DON stated the expectation was R8 should have been repositioned according to his care plan. The facility's Pressure Ulcer Prevention & Managing Skin Integrity Policy dated 2/6/18,	F 686	This observance was the result of miscommunication between facility staff and was addressed with staff immediately at the time the observance was brought to the attention of the staff members. R8's repositioning schedule was reviewed with all staff during shift change for not less than 24 hours after the incident. Facility Wide Response Addressing Other Residents with the Potential to be Affected: 1. Facility staff have reviewed repositioning schedules identified in residents' care plans and are now tracking when resident's are repositioning utilizing an electronic tracking record. Licensed nursing and trained medication assistants will review compliance using the tracking record at multiple variables during their shift. 2. Ongoing: Quarterly Audits of a random sample of residents having repositioning schedules will be conducted by nursing leadership to ensure that all of the requirements and facility policy are being met. Data obtained from the aforementioned audits will be incorporated into the facility's Quality Assurance and Performance Improvement (QAPI) program. Recommendations, including recommendations based upon observed data, will be integrated into the QAPI process. Standards of practice and ongoing educational offerings will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN MANOR	501 OAK STREET CHASKA, MN 55318

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 3 indicated in the Skin Inspection, item 4(a) the resident repositioning will be determined by the Tissue Tolerance evaluation and in item 4(b) the interventions would be placed on the care plan.	F 686	incorporated to ensure quality of care and compliance at F 686. Audits will continue for not less than one year.	
F 880 SS=D	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 §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, 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	F 880		1/14/19

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	245604	A. BUILDING _____ B. WING _____	12/05/2018

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F 880	Continued From page 4 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate hand hygiene and glove use for 1 of 1 resident (R20) reviewed for contact precautions.	F 880	Auburn Manor has established and maintains an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and	

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F 880	Continued From page 5 Findings include: R20's diagnosis included multiple sclerosis, personal history of urinary (tract) infections, retention of urine, neuromuscular dysfunction of bladder obtained from the quarterly Minimum Data Set (MDS) dated 10/1/18. R20's physician order dated 11/28/18, indicated "Resident is on contact precautions due to diagnosis of Methicillin-resistant Staphylococcus aureus [MRSA]." On 12/3/18, at 7:43 a.m. to 8:01 a.m. nursing assistant (NA)-B and NA-C were observed get R20 ready for the day. During the observation at 7:56 a.m. after NA-B assisted R20 to turn to the right side then NA-C was observed provide pericare to R20's bottom. NA-C wiped smears of stool off R20's bottom. After NA-C finished, she removed the gloves and then re-applied another pair of gloves and continued to finish R20's cares and touched items in the room without washing her hands. -At 8:00 a.m. NA-B was observed pick a wet soiled foam dressing which was on the bedding at the foot of the bed with his gloved right hand. At this time NA-C asked NA-B to leave the dressing there so the licensed practical nurse (LPN)-B could see it. NA-B set the soiled dressing back on the bed and then removed the gloves and re-applied another pair of gloves without washing hands. -At 8:02 a.m. LPN-B came into room applied gloves and blue gown then approached R20's foot of the bed and asked NA-B to hold R20's right foot for her to complete wound care. LPN-B then was observed use gauze and Normal Saline to clean the wound on the right heel. LPN-B then	F 880	transmission of communicable disease and infection. The survey team cited that three facility staff members did not ensure appropriate hand hygiene and glove use for one resident during a wound dressing change. Immediate remedial measures included 'In Time' training on infection control principles, including appropriate hand hygiene and glove use, for the staff involved. Facility Wide Response Addressing Other Residents With the Potential to be Affected: 1. Appropriate Hand hygiene and glove use was reviewed with all staff during shift change for not less than 24 hours after the incident. 2. Facility direct care staff will receive an educational infection control refresher which will focus on appropriate hand hygiene and glove use. 3. Foamed alcohol dispensers are available in each resident room and is used as an adjunct to hand washing when necessary. The appropriate use of gelled alcohol products will also be discussed at the infection control training sessions. 4. Day-to-day compliance with standard infection control principles will be monitored and enforced by the licensed nursing staff.	

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F 880	Continued From page 6 pat dried the area used a Q-tip to apply Santyl cream (used to remove dead tissue from a wound) to the wound then removed the gloves and re-applied another pair of gloves without washing or cleansing hands before applying a foam dressing to the wound. -At 8:46 a.m. NA-C verified she had not washed her hands after pericares and stated she was supposed to wash them. -At 8:47 a.m. LPN-B stated she had the hand sanitizer in her pocket but did not want to reach into the pocket during the observation "at least I changed the gloves." LPN-B further stated she was supposed to have washed her hands when going from dirty to clean during wound care. On 12/05/18 12:59 PM the director of nursing (DON) stated the staff were supposed to wash their hands after providing peri-care before continuing with cares. The DON stated LPN-B was supposed to have washed hands or used hand sanitizer after she had cleaned the wound and removing her gloves before proceeding with applying a clean dressing on the wound. When asked where the MRSA infection was in R20's body, the DON stated it was in the wound on the coccyx. The facility Standard Precautions policy dated 5/2018, directed staff hand washing/hand hygiene was generally considered the single most important procedure for preventing healthcare-associated infections. The policy directed staff to wash hand after removing gloves, before and after performing any invasive procedure and if hands were moving from a contaminated body site to a clean body site during care and after any contaminating contact.	F 880	5. Ongoing: Quarterly random sample audits of appropriate hand hygiene and glove usage will be conducted as part of the QAPI Program. Data obtained from the quality assurance process will be reviewed, with recommendations for intervention made, during the quarterly QAPI Meetings for not less than one year.	

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	245604	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/04/2018**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division, on December 04, 2018. At the time of this survey, Building 01 of Auburn Manor 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/21/2018

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 Health Care 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 description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Building 01 of Auburn Manor is a one-story building with no basement. The original building was constructed in 1988, with one building addition constructed in 1992. Both buildings are fully fire sprinkler protected and were determined to be of Type II(111) construction. A 2006 building addition, which is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type V(111) construction. Both building were surveyed as one. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The nursing home is separated from an attached assisted living facility	K 000		

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K 000	Continued From page 2 by complying two-hour fire wall assemblies. The facility has a capacity of 61 beds and had a census of 53 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 281 SS=F	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to provide the level of lighting as required by the Life Safety Code, (NFPA 101) 2012 edition section 7.8.1.4. This deficient practice could reduce the illumination of the exits and affect an undetermined amount of staff and visitors. Findings include: On the facility tour between 9:00 AM to 12:00 PM on 12/06/2018 observations revealed the exterior light on the exit discharge at the Kitchen, Main Entrance and the Laundry had only one bulb for illumination. This deficient condition was confirmed by the facility Maintenance Supervisor.	K 281	It is the policy and intention of Auburn Manor to be in compliance with all regulations and requirements of both the Medicaid and Medicare Programs as well as Life Safety Code requirements for health occupancies as outlined in NFPA 101 (2012). On 12/6/18, during the facility tour and documentation review, it was noted that the illumination at several areas of egress was not compliant with NFPA 101 (2012). Plan of Correction: 1. The identified areas of illumination will be connected to the emergency generator to ensure continuous operation or automatic operation.	1/14/19

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K 281	Continued From page 3	K 281	2. The identified illumination will be replaced with LED lighting to ensure adequate illumination. 3. The facility□'s risk management committee will monitor illumination at areas of egress at the facility to ensure that the requirement is met on an ongoing basis.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to provide documentation of fire drills at least quarterly on each shift as required by the Life Safety Code (NFPA 101) 2012 edition, section 19.7.1.4 to 19.7.1.7. This deficient practice could reduce the ability of staff to conduct a safe and timely response to a fire emergency, which would affect all residents and an undetermined amount of staff and visitors. Findings include:	K 712	It is the policy, and intention, of Auburn Manor to be in compliance with all regulations and requirements of both the Medicaid and Medicare Programs as well as all Life Safety Code requirements for health care occupancies as outlined in NFPA 101 (2012 edition). K 0712 NFPA 101 FIRE DRILLS Fire drills are held at unexpected times under varying conditions, at least quarterly	1/14/19

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K 712	Continued From page 4 On 1206/2018 between 9:00 AM and 12:00 PM, documentation reviewed revealed fire drills were not performed correctly during these times: 1) 2nd quarter 2nd shift This deficient condition was confirmed by the facility Maintenance Supervisor.	K 712	on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualilfied to exercise leadership. On 12/6/18 it was noted that the facility had not completed a required fire drill during the 2nd quarter on the 2nd shift. Plan of Correction: 1. Facility staff responsible for conducting quarterly fire drills have reviewed and have been re-educated on the requirement addressing fire drills in the 101 Life Safety Code Standard and facility policy and procedure. 2. The facility□s chief engineer will be responsible for conducting quarterly fire drills on each shift at unexpected times., and completing all required documentation. The facility□'s safety committee will monitor fire drills both scheduled and completed at the facility to ensure that the requirement is met on an ongoing basis.	
K 923 SS=C	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet	K 923		1/14/19

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K 923	Continued From page 5 Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to store oxygen tanks in accordance with NFPA 99 (Health Care Facilities Code) 2012 edition section 11.6.2.3 item 11. This deficient practice could create an oxygen filled atmosphere and accelerate the spread of fire. This condition could affect all of the 61 residents and an	K 923	It is the policy and intention of Auburn Manor to be in compliance with all regulations and requirements of both the Medicaid and Medicare Programs as well as Life Safety Code requirements for health occupancies as outlined in NFPA 99.	

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K 923	Continued From page 6 undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 12:00 PM on 12/06/2018 observations and staff interview revealed: 1) E- Cylinders were not separated. This deficient condition was confirmed by the facility Maintenance Supervisor	K 923	On 12/6/18, during the facility tour and documentation review, co-mingled full and empty oxygen tanks were found to be stored together in the same area. Plan of Correction: 1. The facility's chief engineer is responsible for overseeing the safe storage and handling of oxygen. The engineer has established both full and empty oxygen tank storage compartments designed to meet the requirements for safe oxygen storage. 2. The facility's risk management committee will be conducting monthly oxygen storage audits for three months, and semi-annually thereafter, to ensure compliance with the requirements outlined in NFPA 99.	