STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245583	A. Building B. Wing	02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Auburn Home IN Waconia	594 Cherry Drive Waconia, MN 55387

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40943 Based on interview and document review, the facility failed to the facility failed to ensure a resident's morning routine preferences were honored for 1 of 1 residents (R26) who voiced concerns about morning routines. Findings include: R26's admission Minimum Data Set (MDS) dated [DATE], identified R26 was cognitively intact and R26 felt it was very important that she was able to choose what to wear and to choose her bedtime. R26's care plan dated 2/9/24, identified R26 had hypersomnia (a condition in which you feel extreme daytime sleepiness despite getting sleep that should be adequate (or more than adequate) and insomnia (trouble falling asleep, staying asleep, or getting good quality sleep). R26's preference was to wake up at 9:30 a.m. R26's Island Household care sheet updated 2/1/24, identified R26 required assist of 1 for Activities of Daily Living (ADL's). Special instructions included try not to rush R26, R26 gets anxious and let her sleep until 9 or 10, whatever she wants. During an observation on 2/28/24 7:14 a.m., R26 was in bed with her blankets pulled up to her chin. R26 did not respond to door knocking and the room was dark with the window blinds closed. - at 9:00 a.m., unchanged. - at 9:30 a.m., nursing assistant (NA)-F was observed to open R26's room door but shut it again. During an observation on 2/28/24 at 12:11 p.m., R26 was seated in her easy chair eating her lunch meal. R26 was wearing a teal-colored robe and stated she was fine but had slept until after 11:00 a.m. R26 stated the girl was nice but R26 usually liked to get up at 9:30 a.m. and did not like to sleep so late. R26 stated she was unable to receive cares because she rose too late, and the nursing assistant needed to serve the lunch meal. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/28/24 at 1:15 p.m., NA-F stated she did not offer to get R26 up at 9:30 a.m. because R26 was sleeping. NA-F reviewed the Island Household care sheet and stated R26 was to get up whenever she wants, and that meant when R26 woke up and used her call light. NA-F stated she assisted R26 to change her catheter bed bag to a leg bag but did not dress R26 because she needed to be in the dining room for the lunch meal. During an interview on 2/28/24 at 1:31 p.m., registered nurse (RN)-A stated stated R26 changed her mind a lot about what time she wanted to get up for the day. 9:30 a.m. was the time R26 said she wanted to get up. Some days she did and other days did not. R26 did not want to be woken up before 9:30 a.m., but other days she wakes on her own before 9:30 a.m. Staff were expected to go into R26's room at 9:30 a.m. and offer to assist her. During an interview on 2/28/24 at 1:54 p.m., the director of nursing (DON) stated staff were expected to follow R26's care plan and to offer assistance with morning cares at 9:30 a.m. per R26's request. The facility policy Person-centered Care Planning dated 10/2017, identified residents shall be groomed as they wish to be groomed. The comprehensive care plan would include but was not limited to services that were to be furnished to attain and maintain the resident's highest practicable physical, mental, and psychosocial well-being. A facility policy regarding Resident Rights was requested but not received.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42075 Based of observation, interview, and document review, the facility failed to ensure the nursing assistant care plan was revised to reflect updated care planned interventions for 1 of 4 residents (R15) reviewed for falls Findings include: R15's quarterly Minimum Data Set (MDS) dated [DATE], identified R15 had severe cognitive impairment, used a wheelchair for mobility, required substantial/maximal assistance (helper does more than half the effort) with transfers, and required partial/moderate assist to ambulate 10 feet. R15 had one fall since previous review. The Elm Household care sheet (nursing assistant care plan in the book) updated 1/3/24, directed staff to offer to stand/walk R15 if restless, and to ambulate the resident with stand-by-assist using a walker and pulling the wheelchair behind. The care sheet did not reflect the updated care plan dated 1/30/24, below. R15's care plan dated 1/30/24, identified R15 had a mobility and self-care deficit and was at risk for falls related to weakness, impulsivity, and a history of recurrent falls. Interventions dated 4/27/21, identified R15 was not safe to ambulate and was not able to cooperate and participate with physical therapy (PT) to work on the issue. On 2/27/24 at 6:39 p.m., nursing assistant (NA)-B stated staff were to look at the Elm NAR Book or the paper chart to find a residents care plan. On 2/28/24 at 7:22 a.m., NA-D stated she was not told where the care plans were. NA-D looked through the Elm NAR Book and stated the care sheets were the care plan. The care sheets showed what each resident needed for care. On 2/28/24 at 11:19 a.m., registered nurse (RN)-A stated the NA care plans were located in the books at the nurses stations, and were updated according to the MDS schedule and if there are changes. RN-A would be notified from the nursing staff if there was a change in a residents status and it was her responsibility to update the care plan, care sheets and notify the staff of changes. When asked if R15's care sheets and care plan were updated, RN-A stated she was uncertain and would have to review them in detail. The facility policy Person-centered Care Planning dated 10/2017, identified the facility would develop and implement a person-centered comprehensive care plan for each resident within 7 days of the completion of the comprehensive assessment. Comprehensive care plans must be reviewed and revised quarterly and as needed by the interdisciplinary team. Person-centered care [NAME] would be used by all personnel involved in the care of the resident.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40943 Based on observation, interview and document review failed to provide oral and toileting/incontinence cares for 1 of 4 residents (R25); and failed to provide timely assistance with toileting/incontinence care for 1 of 4 residents (R15) reviewed for activities of daily living (ADL) and who were dependent on staff for ADL's Findings include: R25's quarterly Minimum Data Set (MDS) dated [DATE], identified R25 had a severe cognitive impairment and disgnoses included dementia with behavioral disturbance, Alzheimer's disease, anxiety, aphasia (loss of ability to understand or express speech, caused by brain damage), dysphagia (difficulty swallowing) pain, and peripheral vascular disease. R25 was frequently incontinent of bowel and bladder and was dependent on staff for all care areas. R25's Speech Therapy Outpatient Clinic SLP Eval and Plan of Treatment dated 4/10/23, identified a recommendation of puree food with ok for mechanical soft snacks when R25 was sitting upright and alert. Continue thin liquids. At that time, R25 was not appropriate for complete mechanical soft diet due to changing of alertness; placing R25 at risk for increased pocketing or aspiration/choking. R25's TENA/SCA Bladder assessment dated [DATE], identified R25 was not appropriate for a toileting or retraining due to advanced dementia and was to continue routine toileting. R25's care plan revised 12/27/23, identified R25 required extensive assistance of 1-2 for oral care. Staff were directed to provide oral cares 2-3 times per day prevent aspiration pneumonia per the speech language pathologist (SLP). The care plan also identified R25 at risk for falling related to dementia with behavioral disturbance, non-ambulatory/wheelchair bound, reduced mobility, weakness, and history of falls. Staff were directed to provide toileting assistance and check for incontinence every 2 hours. During a continuous observation on 2/27/24 at 3:24 p.m., R25 was sitting in his wheelchair in the common area by the tv. R25 was seated upright and R25's chin was resting on his chest. R25 had an overbed table in front of him with an activity blanket on top of the table. - At 4:05 p.m., R25 continued to sit in his wheelchair without a change in position. - At 4:12 p.m., nursing assistant (NA)-C approached R25 and assisted R25 to drink his supplement. NA-C did not offer to toilet or check for incontinence R25. - At 4:44 p.m., NA-C assisted R25 to the dining room for his supper meal. NA-C did not offer to toilet or check for incontinence R25. - At 5:35 p.m., R25 was finished with his supper meal. NA-G assisted R25 from the dining room to the common area to watch tv. NA-G did not offer to toilet /check for incontinence, or oral cares to R25. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- At 6:16 p.m., licensed practical nurse (LPN)-B and NA-F assisted R25 to his room. NA-F told LPN-B they would get R25 ready for bed because R25 was already sleeping. - At 6:18 p.m., NA-F removed R25's shirt and placed a gown on R25. R25 was transferred into bed using a standing lift. - At 6:24 p.m., R25's pants and wet incontinence brief were removed. LPN-B took a wet washcloth and ran it over R25 perineum. R25's skin was not dried with a towel and a new incontinence brief was placed on R25. - At 6:29 p.m., LPN-B and NA-F covered R25 with blankets. R25 was not offered oral cares. LPN-B and NA-F exited R25's room. During an interview on 2/27/24 at 6:30 p.m., LPN-B stated she could not say offhand what R25 required for care and would have to review R25's care plan. - At 6:33 p.m., LPN-B reviewed R25's Elm Household care sheet and stated she didn't know R25 needed oral cares and without reviewing the care sheet she would not have known. Additionally, R25 should have been offered toileting every two hours. During an interview on 2/27/24 at 6:36 p.m., NA-F stated it was her understanding R25 was toileted every two hours, and checked him at 3:00 p.m. when she started her shift. NA-F explained they stood him up and checked for the blue line on his brief but there wasn't one. NA-F stated she believed staff placed R25 on the toilet in the daytime. Staff never placed R25 on the toilet in the evening because R25 didn't do anything on the toilet because he was already incontinent by that time. - At 6:56 p.m., NA-F stated there was usually a nursing assistant on each wing and there was a short shift as well. There was also a nurse and medication nurse. NA-F stated it was hard to toilet R25 every 2 hours because she arrived at 3:00 p.m. and 2 hours is 5:00 p.m., which was when the staff served supper. NA-F stated she was the only nursing assistant there and it was her responsibility to get all the residents to the dining room. NA-F stated it was important to follow R25's care plan because it was his right to receive the care he needs. Additionally, NA-F did not know R25 needed oral cares. During an interview on 2/27/24 at 7:11 p.m., NA-B stated R25 needed a lot of help. NA-F believed R25 should be toileted twice a shift. During an interview on 2/28/24 at 9:08 a.m., NA-A stated R25 needed to be toileted every 2 hours and should be placed on the toilet. For example, R25 should be placed on the toilet at approximately 9:45 a.m. Staff needed to give him approximately 10 minutes to relax and R25 will be able to pass on a bowel movement on the toilet. During an interview on 2/28/24 at 1:40 p.m., registered nurse (RN)-A stated R25 should be toileted on a toilet every two hours. Staff were expected to follow R25's care plan and were expected to review the care plan to know what each individual resident required for care. Additionally, not providing oral cares for R25 placed him at risk for aspiration pneumonia. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/28/24 at 2:17 p.m., the director of nursing (DON) stated staff were expected to know what each individual resident was care planned for and to follow the care plan. 42075 R15's quarterly MDS dated [DATE], identified R15 had severe cognitive impairment, and long and short term memory problems. R15's diagnoses included Alzheimer's disease, bipolar disorder, and impulsiveness.R15 was dependent on staff for toileting and required assistance for transfers on/off the toilet. R15's care plan, dated 7/31/20, identified R15 had an abnormal gait, weakness with impulsivity, history of repeated falls and mental health issues/behaviors causing fluctuations in performance. Interventions included 1-2 staff to assist R15 to move between surfaces, and 1 staff to assist with transfers on/off the toilet every two hours and as needed. On 2/27/24, R15 was continuously observed from 3:24 p.m. through 6:04 p.m. R15 was seated in his wheelchair in the common area near the nurses station and in the dining room. R10 remained seated in his wheelchair until LPN-B and nursing assistant (NA)-C assisted R15 onto the toilet at 6:04 p.m., a total of 2 hours and 40 minutes since the last time R15 was toileted. On 2/27/24 at 06:11 p.m., LPN-B stated she was uncertain the last time R15 was toileted but knew R15 should be toileted every two hours. On 2/27/24 06:11 p.m., NA-C stated according to R15's care plan, the resident should be toileted every 2 hours. NA-C toileted R15 at 3:00 p.m., and then again at 6:04 p.m., which was 3 hours and 4 minutes, and over the two hour recommendation for toileting. and NA-C was unable to toilet R15 as she was in the dining room. On 2/29/24 at 11:19 a.m., RN-A stated generally residents were toileted when they get up, before/after activities and meals, which was roughly ever 2 hours. The NA's have a care plan in their books at the nurses station and is updated whenever there were changes to the care plan. R15 should be toileted every two hours and gets agitated when he has to use the toilet. A facility policy regarding ADL's was requested but not received.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40943 Based on observation, interview and document review, the facility failed to ensure interventsion for preventing pressure ulcers were implemented for 1 of 2 residents (R25) reviewed who was at risk for the development of pressure ulcers. Findings include: R25's quarterly Minimum Data Set (MDS) dated [DATE], identified R25 had a severe cognitive impairment and had diagnoses that included dementia with behavioral disturbance, Alzheimer's disease, anxiety, aphasia (loss of ability to understand or express speech, caused by brain damage), dysphagia (difficulty swallowing) pain, and peripheral vascular disease. R25 was at risk for pressure ulcers. R25's care plan revised 12/27/23, identified R25 was at risk for pressure ulcers related to end stage Alzheimer's disease, incontinence, reduced mobility, non-ambulatory/wheelchair bound, and spinal kyphosis. Interventions included: - Foot cradle on bed to reduce pressure to feet/toes related to redness to tops of big toes. - Turn and reposition every 2 hours. - Keep clean and dry as possible. Minimize skin exposure to moisture. R25's Braden Scale for Predicting Pressure Sore Risk 2023 dated 12/19/23, identified R25 was at moderate risk for pressure ulcer/injury. Interventions included pressure reducing device for chair and bed, and application of ointments/medications. During a continuous observation on 2/27/24 at 3:24 p.m., R25 was sitting in his wheelchair in the common area by the tv. R25 was seated upright but chin was resting on his chest. R25 had an overbed table in front of him with an activity blanket on top of the table. - At 4:05 p.m., R25 continued to sit in his wheelchair without a change in position. - At 4:12 p.m., nursing assistant (NA)-C approached R25 and assisted R25 to drink his supplement. NA-C did not offer to reposition R25. - At 4:44 p.m., NA-C assisted R25 to the dining room for his supper meal. NA-C did not offer to reposition R25. - At 5:35 p.m., R25 was finished with his supper meal. NA-G assisted R25 from the dining room to the common area to watch tv. NA-G did not offer to reposition to R25. - At 6:16 p.m., licensed practical nurse (LPN)-B and NA-F assisted R25 to his room. NA-F told LPN-B they would get R25 ready for bed because R25 was already sleeping. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- At 6:18 p.m., R25 was transferred into bed using a standing lift. R25's bed had a foot cradle tucked under the mattress at the foot end. - At 6:24 p.m., R25's pants and wet incontinence brief were removed. LPN-B took a wet washcloth and ran it over R25 perineum. R25's skin was not dried with a towel and a new incontinence brief was placed on R25. - At 6:29 p.m., LPN-B and NA-F covered R25 with blankets. R25's blankets were not placed on the foot cradle and were in direct contact with R25's feet. LPN-B and NA-F exited R25's room. During an interview on 2/27/24 at 6:30 p.m., LPN-B stated she could not say offhand what R25 required for care and would have to review R25's care plan. - At 6:33 p.m., LPN-B reviewed R25's Elm Household care sheet and stated she didn't know he needed to use a foot cradle, nor that he had one, and without reviewing the care sheet she would not have known. R25 should have been offered repositioning every two hours. On 2/27/24 at 6:36 p.m., NA-F stated she did not know if R25 was at risk for pressure ulcers and did not know what the staff did to prevent them for R25. During the observation, NA-F asked if the equipment on the end of R25's bed was the foot cradle, untucked his blankets and placed them over the foot cradle elevating the blankets off R25's feet. NA-F stated she was just going to be honest and say she did not know what the foot cradle was nor had ever seen a staff member use it. - At 6:56 p.m., NA-F stated there was usually a nursing assistant on each wing and there was a short shift as well. There was also a nurse and medication nurse. NA-F stated it was hard to reposition R25 every two hours because she arrived at 3:00 p.m. and two hours is 5:00 p.m., which was the staff served supper. NA-F stated she was the only nursing assistant there and it was her responsibility to get all the residents to the dining room. NA-F stated it was important to follow R25's care plan because it was his right to receive the care he needed. During an interview on 2/27/24 at 7:11 p.m., NA-B stated R25 needed a lot of help. NA-F believed R25 should be repositioned twice a shift. During an interview on 2/28/24 at 9:08 a.m., NA-A stated R25 needed to be repositioned every two hours. During an interview on 2/28/24 at 1:40 p.m., registered nurse (RN)-A stated R25 should be repositioned every two hours to prevent pressure ulcer. Staff were expected to follow R25's care plan and were expected to review the care plan to know what each individual resident required for care. During an interview on 2/28/24 at 2:17 p.m., the director of nursing (DON) stated staff were expected to know what each individual resident was care planned for and to follow the care plan. A facility policy regarding pressure ulcers was requested but not received.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42075 Based on observation, interview, and document review, the facility failed to ensure residents were appropriately supervised to prevent falls for 1 of 2 (R15) resident reviewed for falls. In addition, the facility failed to ensure care planned fall interventions were utilized for 1 of 2 residents (R25) reviewed for falls. Findings include: R15's quarterly Minimum Data Set (MDS) dated [DATE], identified R15 had severe cognitive impairment, and diagnoses included Alzheimer's disease and bipolar disorder. R15 used a wheelchair for mobility, required substantial/maximal assistance (helper does more than half the effort) with transfers, and required partial/moderate assist to ambulate 10 feet. R15 had one fall since previous review. The facilities undated Walking/ROM Program identified on 3/15/22, R15 was not safe to ambulate; staff try to intercept when resident was attempting to walk and redirect to chair or bed. Staff may need to assist with two staff and hand-held-ambulation to walk resident to bed/chair if resident was agitated and insisted on walking. The Elm Household care sheet updated 1/3/24, directed staff to offer to stand/walk R15 if restless, and to ambulate the resident with stand-by-assist using a walker and pulling the wheelchair behind. The facility Fall Risk assessment dated [DATE], identified R15 was a high risk for falls, was confined to a chair, and used a wheelchair for locomotion. R15's care plan dated 1/30/24, identified R15 had a mobility and self-care deficit and was at risk for falls related to weakness, impulsivity, and a history of recurrent falls. Interventions dated 4/27/21, identified R15 was not safe to ambulate and was not able to cooperate and participate with physical therapy (PT) to work on the issue. On 2/27/24, the following was observed: - At 4:45 p.m., R15 was seated in his wheelchair in the commons area, a bedside table was next to him, and no staff were present. R15 stood up, rested his left hand on the table next to him and stepped away from the wheelchair. - At 4:46 p.m., NA-B walked into the commons area, looked at and approached R15. NA-B encouraged the resident to sit down in his wheelchair. Suddenly, with a thump, R15 sat down. NA-B wheeled R15 into the dining room and pushed the resident up to a table. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/27/24 at 4:49 p.m., R15 gently pushed his wheelchair away from the dining room table and stood tall. No staff were observed in the dining room. An unidentified male resident was seated at another table and loudly yelled help for [R15]. Staff walked into the dining room, assisted R15 to sit down his wheelchair, then turned and walked away without looking back at the resident. R15 attempted to stand again. Before the staff member exited the dining room, she turned back towards R15, and returned to sit next to the resident. On 2/27/24 at 6:13 p.m., R15 was seated in his wheelchair in the commons area near the nurse's station. No staff observed in the area. R15 stood, stepped forward and away from his wheelchair and continued to stand for 20 seconds, then stepped back and sat in his wheelchair. -At 6:33 p.m., R15 continued to be seated in the commons area. Licensed practical nurse (LPN)-B, NA-A and NA-B approached the nurse's station and stood with their backs towards R15. R15 stood and took 5 steps away from his wheelchair and towards a rocking chair in the corner of the room. LPN-B, NA-A and NA-B continued to have their backs towards R15 and were not observed to look over at R15. R15 was leaning forward and was not standing upright. At 6:34 p.m., R15 was standing, not holding onto anything, leaning forward and towards the rocking chair in the corner of the room. The state agency (SA) intervened and called out to staff at the nurses station. NA-C walked to resident and encouraged R15 to sit in his wheelchair. After a minute or so, R15 sat down. On 2/27/24 at 6:37 p.m., NA-C stated R15 requires assist of 1 staff for transfers, and staff were to observe the resident when he was in the commons area because he would try to stand on his own. On 2/27/24 at 6:39 p.m., NA-B stated R15 was at risk for falls and staff were to observe the resident every hour when he was in common areas. Some days R15 would be active and up/down, standing/sitting and would at times attempt to walk. Staff did their best to supervise R15 but there were times that staff were not available to monitor him. Staff were to look at the Elm NAR Book or the paper chart to find a resident's care plan. NA-B stated there was not a care plan for R15 in the book and was uncertain why it wasn't there. The most up-to-date care plan would be in the resident's paper chart. R15 was a fall risk and could potentially fall and injure himself when walking on his own. Further, NA-B stated when there were no staff present to prevent R15 from standing or walking on his own. On 2/28/24 at 3:14 p.m., registered nurse (RN)-A stated R15 had times when he was more active, more behavioral, and up/down in his wheelchair. During these times R15 was at risk for injuring himself, other residents and potentially staff. Staff were to attempt to redirect the resident with snacks, repositioning, get him involved with something on the unit, offer to lay down in bed, or 1:1 supervision. RN-A stated she expected staff to stay with the resident during these times, however long it took. Staff were expected to write a progress note regarding what happened and what staff did for interventions. It was ultimately the responsibility of the nurse in charge to assign a staff member to sit with the resident when needed. 40943 R25's quarterly MDS dated [DATE], identified R25 had a severe cognitive impairment and had diagnoses that included dementia with behavioral disturbance, Alzheimer's disease, anxiety, and paranoid personality disorder. R25 was dependent on staff for all care areas. (continued on next page)

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Auburn Home IN Waconia	594 Cherry Drive Waconia, MN 55387

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R25's care plan revised 12/27/23, identified R25 was at risk for falling related to dementia with behavioral disturbance, nonambulatory/wheelchair bound, reduced mobility, weakness and history of falls. Staff were directed to ensure R25 was provided proper, well-maintained footwear. R25's Fall Risk assessment dated [DATE], identified R25 was at high risk for falls. During an observation on 2/27/24 at 9:01 a.m., R25 was sitting in his wheelchair in the common area. R25 was wearing socks without grippers. During an observation on 2/27/24 at 3:24 p.m., R25 was seated in his wheelchair in the common area. R25 was wearing socks without grippers. During an interview on 2/27/24 at 6:30 p.m., licensed practical nurse (LPN)-B stated she was unable to say what R25 required for cares and would have to review R25's care plan. - At 6:33 p.m., LPN-B stated R25 should have been wearing proper footwear due to being at risk for falls. During an observation on 2/28/24 at 7:10 a.m., R25 was seated in his wheelchair in the common area. R25 was wearing socks without grippers. During an observation on 2/28/24 at 3:20 p.m., R25 was seated in his wheelchair in the common area. R25 was wearing socks without grippers. During an interview on 2/28/24 at 3:29 p.m., NA-H and NA-I stated R25 was not at risk for fall. NA-I stated R25 was not able to move on his own and never did but had a floor mat next to his bed. When asked why R25 had a floor mat, NA-I stated the floor mat was a fall intervention, but NA-I did not know why R25 would be a fall risk. Upon review of R25's care sheet, NA-I stated R25 always just work regular socks. R25 did have slippers, but if R25 was a fall risk day shift should have put them on. NA-I never put anything but regular socks on R25. During 2/28/24 at 3:59 p.m., registered nurse (RN)-A stated R25 should wear at least gripper socks to prevent falls. During an interview on 2/28/24 at 4:17 p.m., the director of nursing (DON) stated staff were expected to know what each individual resident was care planned for and to follow the care plan. R25 was at risk for falls and staff were expected to place proper footwear on R25. The facility policy Accident: Managing Resident Falls reviewed 8/15/18, identified evaluation and analyzing hazard(s) and risk(s) for potential resident falls would occur upon admission, quarterly, annually, and as needed. Staff in conjunction with the interdisciplinary team (IDT), resident and/or resident representative would implement the resident's plan of care with interventions to reduce the risk of falls, if appropriate.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40943 Based on observation, interview, and document review, the facility failed to ensure adequate catheter care for 1 of 1 (R26) residents reviewed for catheter cares. Findings include: R26's admission Minimum Data Set (MDS) dated [DATE], identified R26 was cognitively intact and had diagnoses that included urinary tract infection (UTI) and reflex neuropathic bladder (the name given to a number of urinary conditions in people who lack bladder control due to a brain, spinal cord or nerve problem)a. R26 used a indwelling foley catheter and required substantial assistance with toileting hygiene (the ability to maintain perineal hygiene, adjust clothes before and after using the toilet, commode, bedpan, or urinal. If managing an ostomy, include wiping the opening but not managing equipment). R26's care plan dated 2/9/24, identified R26 required an indwelling urinary catheter. Interventions included to keep the catheter system closed as much as possible and manipulate tubing as little as possible during care. The care plan also identified R26 exhibited moblility and self-care deficiencies due to tremors, balance problems, weakness and fatigue. Staff were directed to provided partial to moderated assistance to transfer on/off toilet and substantial to maximum assistance to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. R26's Island Household Care sheet updated 2/1/24, identified R26 had a foley catheter. Special instructions included: need urinary output every shift, needs good peri-care in morning and at bedtime (must be done), and let R26 sleep until 9:00 a.m. or 10:00 a.m., whatever R26 wants. R26's nursing progress note dated 2/5/24 at 11:17 a.m., identified R26's urinalysis and culture showed greater than 100,000 colony forming unit (CFU)/milliliter (ml) of Klebsiella pneumoniae. Orders were received to start Ciprofloxacin (an antibiotic) 250 milligram (mg) twice a day for 5 days for UTI. During an observation on 2/28/24 at 12:11 p.m., R26 was seated in her easy chair and was wearing a bathrobe. R26 was eating her dinner meal on an overbed table in front of her. R26 stated she had slept until after 11:00 a.m. and she normally was up by 9:30 a.m. R26 stated the nursing assistant was nice, but R26 did not want to sleep that late and wasn't able to receive morning cares because it was dinner time. - 12:13 p.m., R26 stated to look at the state of her bathroom. Next to the toilet, on the grab bars, was a catheter bed bag containing approximately 600 ml of light-yellow liquid. The catheter tubing was open and uncapped. R26 stated that's urine and stated staff routinely left her catheter bag with urine in it. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/28/24 at 1:15 p.m., R26's remained hanging on the grab bar unchanged. Nursing assistant (NA)-F stated R26's catheter bag still had urine in it because R26 was sitting on the toilet when NA-F exchanged the bed catheter bag for a leg bag. NA-F stated she should have emptied and cleaned the catheter bag when she unhooked it from R26 for infection prevention but needed to be in the dining room for the meal. During an interview on 2/28/24 at 1:31 p.m., registered nurse (RN)-A stated R26's catheter bag should not be left with urine in it, unhooked from R26, for infection prevention. R26 was at high risk for UTI. RN-A stated she expected staff to complete catheter care before leaving R26's room. If staff were unable to complete a task, staff were expected to request assistance from a team member. During an interview on 2/28/24 at 1:54 p.m., the director of nursing (DON) stated staff were expected to complete catheter care prior to their next task due to increased risk for infection. The facility procedure undated, identified the following: 1. Both bags require the same care once it is disconnected from the catheter. 2. Wash the outside of the bag in warm soapy water and rinse thoroughly with warm water. 3. Inject a vinegar and water mixture into the bag and let it soak for 20 minutes in the basin. (The ratio is I cup of vinegar to I quart of water.) Be careful not to touch the syringe to the tubing and if this occurs wipe with alcohol wipes. 4. Place the cover over the tubing. (Remember not to throw it away!) 5. After 20 minutes dump out the vinegar mixture in the toilet and rinse with warm water 6. Place the cover over the tubing. 7. Place in the catheter kit to dry in a clean plastic bag.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42075 Based on observation, interview and document review, the facility failed to ensure post-dialysis access site monitoring was consistently completed to provide continuity of care and reduce the risk of complication (i.e., bleeding, clotting) for 1 of 1 residents (R6) reviewed for dialysis care. Findings include: R6's quarterly Minimum Data Set (MDS) dated [DATE], identified R6 was cognitively intact and received dialysis (process of removing excess water and waste products from the blood when kidneys can no longer perform that function adequately). In addition, R6's diagnoses included end stage kidney disease, coronary artery disease (a disease caused by plaque buildup in the wall of the arteries that supply blood to the heart), chronic heart failure (chronic condition in which the heart doesn't pump blood as well as it should), and peripheral vascular disease (abnormal narrowing of arteries). R6's care plan dated 2/19/21, identified R6 had a left arm fistula. Interventions included dialysis per schedule, monitor fistula site by auscultating thrill (a vibration caused by blood flowing through the fistula and can be felt by placing your fingers just above your incision line) and listen for bruit (a whooshing sound) , monitor site and notify MD of signs/symptoms of infection (fever, chills, hypotension, redness, swelling, local warmth, exudates and tenderness), no blood pressure (BP) on left arm, avoid tight clothing or jewelry on left arm, and notify MD or dialysis center if breakthrough bleeding continues more than 30 minutes. R6's orders included staff to check thrill and bruit every shift and not to take blood pressure in the left arm. The facility's treatment flowsheet dated 2/1/24 through 2/29/24, directed staff to check thrill and bruit every shift. FYI: Do not take blood pressure in left arm, Every shift. The report indicated staff failed to document thrill and bruit checks for all three shifts on 6/29 days, including 2 shifts on 2/28/24. On 2/27/24 at 9:20 a.m., R6 stated when she returns to the facility from dialysis, some of the nurses check the dialysis fistula and some don't. On 2/28/24 at 1:37 p.m., R6 was seated in a recliner in her room and stated she returned from dialysis a few minutes prior but the nurse had not checked on her yet. On 2/28/24 at 1:46 p.m., nursing assistant (NA)-A stated R6 returned from dialysis a little after lunch. NA-A stated the nurse was aware R6 returned from dialysis. On 2/28/24 at 2:42 p.m., registered nurse (RN)-B stated when residents return from dialysis the nurse would assess the resident's fistula site for any bleeding, and would palpate the site for thrill and listen for bruit if thrill is not felt. R6 usually returned from dialysis around 10:00 a.m., and RN-B would see the resident, or staff would let her know when the resident returned. RN-B stated she had not seen R6 and was uncertain if R6 returned from dialysis. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/28/24 at 2:52 p.m., R6 stated she had not seen the nurse since returning from dialysis earlier in the day and her fistula site had not been assessed. On 2/28/24 at 2:54 p.m., RN-A stated it was important for nurses to assess a resident to be sure they were stable when they return from dialysis and the assessment should be completed within 30 minutes of the residents return. The assessment would include symptoms of dizziness, feeling light headed, and bleeding from the fistula site. Further, RN-A stated the nurse had not been aware R6 returned from dialysis more than 2 hours late, was unaware why the resident was late and had not assessed R6's dialysis site. On 2/29/24 at 10:42 a.m., a dialysis policy was requested from the Administrator. The administrator stated the facility did not have a policy related to dialysis (including frequency of fistula assessment).

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 40948 Based on interview and document review, the facility failed to submit the payroll-based journal system (PBJ) staffing data to Centers for Medicare and Medicaid Services (CMS) as required. This had the potential to affect all 30 residents residing in the facility. Finding include: The facility's PBJ report 1705D dated 1/29/24, identified the facility failed to submit data for quarter three (April 1 - June 30) and quarter four (July 1 - September 30) of fiscal year 2023. During an interview on 2/29/24 at 9:10 a.m., the administrator identified the staff person who was responsible for submitting the PBJ did not submit the data the third and fourth quarter of fiscal year 2023. The facility's Electronic Staffing Data Submission Payroll-Based Journal policy dated June of 2022, identified direct care staffing and census data would be collected quarterly, and was required to be timely and accurate. The submission must be received by the end of the 45th day after the last day in each fiscal quarter in order to be considered timely.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40943 Based on interview and document review, the facility failed to implement a comprehensive infection control program to include timely surveillance data to identify and prevent the potential spread of communicable disease and infections for 3 of 3 residents (R22, R23, R25) who had identified potential infections. This deficient practice had the potential to affect all 30 residents residing in the facility. Findings include: The facility ABX 2024 Stewardship excel spreadsheet dated January 2024, identified unit, room number, infection type, symptoms, diagnostic test, treatment, transmission-based precautions, and date resolved. The log identified bacterial infections that required antibiotics, however, the log failed to identify/track potential viral infections or communicable rashes. The facility ABX 2024 Stewardship excel spreadsheet dated February 2024, identified unit, room number, infection type, symptoms, diagnostic test, treatment, transmission-based precautions, and date resolved. The log identified bacterial infections that required antibiotics, however, the log failed to identify/track potential viral infections or communicable rashes. The facility ABX 2024 Stewardship excel spreadsheet dated March 2024, identified no information had been entered. R22's significant change MDS dated [DATE], identified R22 was [AGE] years old and had diagnoses that included dementia and chronic obstructive pulmonary disease (COPD) (refers to a group of diseases that cause airflow blockage and breathing-related problems). R22's nursing progress notes identified the following: - On 1/12/24 at 9:29 a.m., R22 felt nauseated in the morning but no emesis. R22 was afebrile, no cough or congestion. R22 had a negative COVID-19 test that morning. R22 was incontinent of a large loose stool. R22 stated she felt better mid-morning. R22 sat comfortable in recliner sleeping. - On 1/14/24 at 12:59 R22 had an occasional cough. Writer tested R22 for COVID-19 via the rapid test which was negative. R22 only let writer swab one nostril. - On 1/15/24 at 8:57 a.m., R22's COVID-19 rapid test was positive. R22 was symptomatic with sinus congestion, expectorating a large amount of clear mucus. R22 was moved into room [ROOM NUMBER] for COVID-19 Isolation; she was the only resident in room [ROOM NUMBER]; all services were provided in room. R23's quarterly MDS dated [DATE], identified R23 was [AGE] years old and had diagnoses that included multiple sclerosis (MS) and dementia. R23's nursing progress notes identified the following: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- On 2/13/24 at 1:48 p.m., R23 was coughing and had a runny nose. - On 2/14/24 at 1:22 p.m., R23 tested negative for COVID via rapid test. - On 2/14/24 at 8:28 p.m., R23 had a cold and a clear, runny nose with noted audible head congestion. R23 had as needed Robitussin twice today. R23 said she felt fine, but she looked tired. However, R23's medical record failed to identify if a confirmatory COVID-19 test was obtained and/or if R23 was placed in TBP until a confirmatory test was obtained. R25's quarterly Minimum Data Set (MDS) dated [DATE], identified R25 was [AGE] years old and had diagnoses that included peripheral vascular disease, and Alzheimer's disease. R25's nursing progress notes identified the following: - On 2/13/24 8:38 p.m., R25 had a clear, runny nose. No coughing noted. R25 had a temperature of 100.2. He received 650 mg of Tylenol (an anti-fever mediation) at 5:00 p.m. At 7:00 p.m., R25's temperature had gone down to 99.0. - On 2/14/24 at 1:22 p.m., R25 was tested for COVID-19 via rapid test which was negative. - On 2/14/24 at 5:29 p.m., R25 had a runny nose (clear). Audible congestion when R25 spoke. R25 was not heard to cough but was given Robitussion (an anti-cough medication) at 1:00 p.m. and 5:00 p.m. R25's temperature was 98.8 Fahrenheit (F). However, R25's medical record failed to identify if a confirmatory COVID-19 test was obtained and/or if R25 was placed in Transmission Based Precautions (TBP) until a confirmatory test was obtained. On 2/28/24 at 11:36 a.m., the facility's infection control log was reviewed with the director of nursing (DON) and the administrator. The log identified bacterial infections that required antibiotics, however, the log failed to identify/track viral infections or communicable rashes. The DON stated the staff nurses entered a progress note in the resident chart and, at the end of the month, and that information was entered onto the spreadsheet. The staff nurses may have another form that they kept on the floor, but the DON would have to verify that. Additionally, no COVID positive residents were listed on the spreadsheet and the DON stated she would need to determine if there was another log that kept track of those residents. - At 11:54 a.m., the director of nursing (DON) stated if resident had signs/symptoms of COVID-19 a rapid antigen test was obtained. If positive, the resident was placed into TBP based on guidance. If negative, the staff may reach out the provider and ask if the provider wanted any further testing such as influenza. If symptoms continued, the resident would be re-tested . However, a symptomatic resident would not be placed into TBP if negative until a confirmatory test was obtained. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 2/29/24 at 9:19 a.m., the DON stated there was no additional log to track COVID positive residents, COVID-19 testing and/or viral or bacterial infection symptoms that did not require antibiotic treatment. The DON provided a word document with a list of COVID-19 positive residents, symptoms, date positive and date isolation was completed. The DON stated staff kept track of ill residents by entering a progress note into the resident's medical record and communicate during report. However, report documentation was disposed of at the end of the nurse's shift. The facility policy COVID-19 Pandemic Action Plan revised 10/17/22, identified a resident with fever or symptoms consistent with COVID-19 would be isolated in their room and placed under transmission-based precautions. After the resident tested positive for COVID-19, the following actions would take place: 1. The facility's DON, Clinical Director or designee would be notified of confirmed COVID-19 infection. 2. A nurse would update both the resident and their representative of positive results and document in the medical record. However, the policy failed to direct staff on processes when a symptomatic resident tested negative for COVID-19. The facility policy Infection Control Program reviewed 2/2023, identified the Infection Control Preventionist and infection control team would implement on-going surveillance for infections among residents/clients and personnel. The Infection Control Preventionist or designee did surveillance of healthcare-associated infections and antibiotic use.

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40943 Based on interview and document review, the facility failed to offer and provide the most recent Centers for Disease Control (CDC) education regarding the potential risks and benefits of the pneumococcal vaccine/ boosters and for 3 of 5 residents (R1, R2, R25) reviewed for immunizations. Findings include: R1's quarterly Minimum Data Set (MDS) dated [DATE], identified R1 was [AGE] years old and had diagnoses that included hypertension, dementia, and chronic obstructive pulmonary disease (COPD) (refers to a group of diseases that cause airflow blockage and breathing-related problems). R1's Minnesota Immunization Report (MIIC) generated 2/28/24, identified R1 received a pneumococcal conjugate vaccine (PCV13) on 10/26/15 and a pneumococcal polysaccharide vaccine (PPSV23) on 3/16/17. R1's medical record did not include evidence R1 or R1's representative received education regarding pneumococcal vaccine booster and there was no indication R1 was offered the pneumococcal vaccine per Centers for Disease Control and Prevention (CDC) guidance. R2's quarterly MDS dated [DATE], R2 was [AGE] years old and had diagnoses that included Alzheimer's disease, and hypertension. R2's MIIC generated 2/28/24, identified R2 received a PCV13 on 2/24/16, and did not identify if R2 received the PPSV23. R2's medical record did not include evidence R2 or R2's representative received education regarding pneumococcal vaccine booster and there was no indication R2 was offered the pneumococcal vaccine per Centers for Disease Control and Prevention (CDC) guidance. R25's quarterly MDS dated [DATE], identified R25 was [AGE] years old and had diagnoses that included peripheral vascular disease, and Alzheimer's disease. R25's MIIC generated 2/28/24, identified R25 received a PCV13 on 1/4/16 and a PPSV23 on 1/15/07. R25's medical record did not include evidence R25 or R25's representative received education regarding pneumococcal vaccine booster and there was no indication R25 was offered the pneumococcal vaccine per Centers for Disease Control and Prevention (CDC) guidance. During an interview on 2/28/24 at 2:36 p.m., the director of nursing (DON), when reviewing R1, R2 and R25's MIIC, stated the record identified each was up to date on their primary series. The DON stated, because of the MIIC did not identify a need for pneumococcal vaccine booster, she was unaware of updated pneumococcal vaccine booster guidelines and had not reviewed resident immunization records to determine who was eligible for pneumococcal vaccine booster. The facility policy Pneumococcal Immunization reviewed 9/4/18, identified the facility would educate and offer the pneumococcal immunization to all residents. The policy did not identify when or how often resident immunization records would be reviewed.