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	11/25/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to timely update the family member (FM) of a change in condition for 1 of 3 residents (R1) to allow family to be involved in decisions for the resident's end of life care.Findings include: R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated R1 was cognitively intact with diagnoses that included Parkinson's Disease (a movement disorder of the nervous system), required a wheelchair for mobility, and substantial/ maximum assistance [helper does more than half the effort] from staff for mobility. R1's progress notes dated 7/21/25 at 12:47 a.m., indicated R1 was nauseated, vomited green fluid, was short of breath, had blood pressure of 72/32 and then 87/57, pain in the right upper quadrant rated as 7 on a scale of 0-10, and a fever of 100.3 degrees Fahrenheit. The on-call administrative staff was notified, and staff left a voice message for the nurse practitioner (NP) were notified, but the progress note lacked indication R1's family was notified. R1's progress notes dated 7/21/25 at 3:31 a.m., indicated R1's condition had not improved, R1 was sent to the hospital, and R1's family was notified, three hours after R1's change in condition. During an interview on 9/23/25 at 2:48 p.m., registered nurse (RN)-A stated R1 was very sick on 7/21/25 in the early morning and had a blood pressure of 72/32 millimeters/mercury (mm/Hg) (blood pressure (BP) lower than 90/60 can reduce oxygen and nutrients a brain receives, leading to brain damage) and the on-call provider was called to report R1's condition, and left a message for the NP and on-call facility administrative staff, but not R1's family. The RN-A acknowledged she did not call the daughter right away, even though she was worried about R1's condition, and further acknowledged R1's low blood pressure was what concerned her enough to want to call the on-call provider. During an interview on 9/23/25 at 4:04 p.m., RN-B stated R1 was sick, and the low blood pressure indicated R1 may have been dying, and the family should have been notified right away so family could be with R1. During an interview on 9/24/25 at 1:18 p.m., RN-C stated R1's family should have been notified when the change of condition occurred, on 7/21/25 around 12:47 a.m. During an interview 9/24/25 at 3:05 p.m., the director of nursing (DON) stated with R1's condition, family should have been notified right away. R1's daughter was involved in R1's care and would have wanted to know when he was not doing well. During an interview on 9/24/25 at 3:36 p.m., the nurse practitioner (NP)-A stated R1's family should have been notified right away when his condition changed, [R1]'s daughter liked to know what was going on with him. The Change of Condition and Provider Notification policy dated 7/29/25, indicated a change in condition is a deviation from an individual's baseline in physical, cognitive, behavioral, or functional status. A change in condition shall be reviewed by a registered nurse. The primary care provider or on-call provider will be contacted. As applicable, the individual representative will be notified. The individual with a change in condition will be monitored as appropriate.

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.

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure the comprehensive care plan was updated to include interventions to address constipation and a bowel program for 1 of 3 residents (R1), who had periods of three or four days between documented bowel movements. Findings include: R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated R1 was cognitively intact with diagnoses that included Parkinson's Disease (a movement disorder of the nervous system that often causes constipation related to slow movement of food through the gut and reduced physical activity), required a wheelchair for mobility, and substantial/ maximum assistance [helper does more than half the effort] from staff for mobility. R1's orders dated 9/24/24, indicated senna-docusate (medication used to relieve constipation, also known as MiraLAX) oral tablet 8.6 milligram (mg), give 2 tablets by mouth in the morning for constipation and give 2 tablets by mouth as needed for constipation, up to 2 times a day. Further, R1's orders dated 9/24/24, indicated polyethylene glycol (a laxative used to treat occasional or chronic constipation), give one packet as needed for constipation, once a day. R1's July medication administration record indicated neither senna-docusate nor polyethylene glycol were administered in July. R1's bowel movement (BM) records indicated a small BM on 7/12/25, a medium BM on 716/25, with no BMs recorded between 7/12/25 and 7/16/25. R1's progress notes lacked mention of assessment for constipation, or intervention after no BM for four days. R1's care plan was reviewed and lacked a focus area or interventions for constipation. During an interview on 9/24/25 at 12:06 p.m., licensed practical nurse (LPN)-A stated constipation interventions should be on a resident's care plan to direct staff on how to manage it. During an interview on 9/24/25 at 3:05 p.m., the director of nursing (DON) stated if a resident had a diagnosis and history of constipation, and was prescribed medications for constipation, there was an expectation to have a care plan to manage constipation. The DON acknowledged R1's care plan did not have a focus area for constipation. The Bowel and Bladder Management policy dated 7/29/25, indicated staff will assess residents for past and present bowel patterns which may include medication review, medical diagnosis, and/or diet. Staff will adopt a person-centered interdisciplinary care plan and implement interventions/approaches to bowel management to meet the goals of the individual and review the care plan at least quarterly. Staff will review individuals that do not have a recorded BM within the past 3 days and provide appropriate intervention.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility delayed the transfer to the hospital after a change of condition, 1 of 3 residents (R1) who had a change in condition. R1's change of condition was identified at approximately 12:45 a.m. and was sent to the hospital at 3:30.Findings include: R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated R1 was cognitively intact with diagnoses that included Parkinson's Disease (a movement disorder of the nervous system that often causes constipation related to slow movement of food through the gut and reduced physical activity), required a wheelchair for mobility, and substantial/ maximum assistance [helper does more than half the effort] from staff for mobility. R1 had chronic pain rated typically at 3 on a scale of 0-10. R1's progress notes dated 7/21/25 at 12:47 a.m., indicated R1 was nauseated, vomited green fluid, was short of breath, had blood pressure of 72/32 and then 87/57, pain in the right upper quadrant rated as 7 on a scale of 0-10 (severe pain), and a fever of 100.3 degrees Fahrenheit. The progress note indicated on-call administrative staff was notified, and staff left a voice message for the nurse practitioner (NP) were notified, but the progress note lacked indication R1's family was notified. R1's progress notes dated 7/21/25 at 3:31 a.m., indicated R1's condition had not improved, R1 was sent to the hospital. R1's progress notes dated 7/21/25 at 3:31 a.m., indicated R1's condition had not improved, R1 was sent to the hospital, and R1's family was notified, nearly 3 hours after R1's change in condition. R1's pain assessments indicated two pain assessments in the previous 90 days. On 7/20/25 at 11:31 p.m., R1 reported pain rated as a 6 on a scale of 0-10 (moderate to moderately strong), and on 7/21/25 at 12:28 a.m., a 7 on a scale of 0-10. R1's orders and Medication Administration Record (MAR) indicated the following:-7/20/25 at 6:51 p.m. administered gabapentin (used to treat nerve pain) oral capsule, give one capsule by mouth as needed for leg pain, dated 1/2/25.-7/20/25 at 11:31 p.m. administered acetaminophen (pain and fever-reducing medication) 500 milligrams (mg), administer 2 tablets by mouth every 6 hours as needed for pain, fever, dated 9/24/24.-7/20/25 at 11:31 p.m. administered albuterol sulfate (used to treat breathing problems) inhalation solution 108 micrograms (mcg)/actuation (ACT) (puff), give 1 puff every 4 hours as needed for spasm of lung air passages, dated 9/24/24. -7/20/25 at 11:36 p.m. administered Zofran (used to treat nausea) oral tablet 4 mg, give one tablet my mouth every 6 hours as needed for nausea, dated 10/21/24. During an interview on 9/23/25 at 2:48 p.m., registered nurse (RN)-A stated R1 was very sick on 7/21/25 in the early morning and had a blood pressure of 72/32 millimeters/mercury (mm/Hg) (blood pressure (BP) lower than 90/60 can reduce oxygen and nutrients a brain receives, leading to brain damage) and decided to call the on-call provider to report R1's condition, and left a message for the NP and on-call facility administrative staff, but not R1's family. The RN-A acknowledged she did not call the daughter right away, even though she was worried about R1's condition. R1's low blood pressure was what concerned her enough to want to call the on-call provider. During an interview on 9/23/25 at 3:14 p.m., nursing assistant (NA)-A stated he worked the night R1 was sent to the hospital. R1 reported pain to NA-A, and asked NA-A to get a nurse. The NA-A stated he told the RN about R1's request for a nurse and then took R1's vital signs at the RN's request, which showed a low BP, low oxygen saturation, and with rapid respirations. R1 vomited black fluid, and the nurse eventually called for an ambulance. NA-A stated when the emergency medical service (EMS) staff arrived one commented the vomit appeared to have blood in it, and thought R1 had a GI bleed. NA-A thought it took about 3 hours to send R1 to the hospital, because the RN was very busy that night. During an interview on 9/24/25 at 1:18 p.m., RN-C stated the nurses were allowed to call 911 when a resident needs emergency assistance and then notify the on-call administrative staff and provider afterwards. RN-C stated R1 should have been sent to the hospital right away, and with a fever, pain, and vomiting, R1 would not have felt very well. RN-C would have expected the nurse to use their judgement to send him to the hospital immediately. During an interview on 9/24/25 at 2:03 p.m., RN-D (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated RN-A called her when R1 was not feeling well, and RN-D advised RN-A to send R1 to the hospital and was not aware RN-A waited three hours to send R1. RN-D stated she was not aware no further assessments were done in the three hours while RN-A waited to send R1 to the hospital but would have expected continuous assessments until R1 went to the hospital. If she did not send him in right away, it was a delay in care. He should have gone right away. It was an emergency. During an interview on 9/24/25 at 3:05 p.m., the director of nursing (DON) stated she was not aware RN-A did not send R1 to the hospital immediately and would question why RN-A didn't send R1 immediately, and why R1 was sent to the hospital by non-emergency transport. The expectation would have been to assess every 30 minutes or more often with vital signs, until R1 was sent to the hospital. The DON acknowledged no further assessments were documented on 7/21/25 between 12:47 a.m., and 3:31 a.m., but stated further assessment should have occurred. The DON further acknowledged R1 was in pain and should have been sent to the hospital sooner to alleviate the pain. During an interview on 9/24/25 at 3:46 p.m., the nurse practitioner (NP)-A stated if RN-A was told to send R1 to the hospital, R1 should have been sent immediately. The NP-A stated she reviewed the hospital records, and R1 would not have been saved if he had been sent to the hospital right away but could have had comfort cares much sooner; R1 was in pain and did not need to be. During an interview on 9/24/25 at 4:21 p.m., the medical director (MD)-A stated it was certainly possible sending R1 to the hospital could have made a difference for him, and staff should have called an ambulance to send R1 to the hospital right away. The (MD)-A stated she would have expected assessment in between the two documented assessments by the nurse to know how the resident's condition was progressing, and the incident should be reviewed by the facility. The Change of Condition and Provider Notification policy dated 7/29/25, indicated a change in condition is a deviation from an individual's baseline in physical, cognitive, behavioral, or functional status. A change in condition shall be reviewed by a registered nurse. The primary care provider or on-call provider will be contacted. As applicable, the individual representative will be notified. The individual with a change in condition will be monitored as appropriate.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to ensure a physician performed an initial comprehensive assessment within 30 days after admission for 1 of 3 residents (R3), failed to ensure physician visits every 30 days after admission for 90 days for 1 of 3 residents (R3) and failed to ensure physician visits every 60 days after the initial 90 days for 3 of 3 residents (R1, R2, R3). Findings include: R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated R1 was admitted [DATE]. R1 was cognitively intact with diagnoses that included Parkinson's Disease (a movement disorder of the nervous system that often causes constipation related to slow movement of food through the gut and reduced physical activity), required a wheelchair for mobility, and substantial/maximum assistance [helper does more than half the effort] from staff for mobility.R1's progress notes dated 7/21/25 at 3:31 a.m., indicated discharge on [DATE].R1's provider visits for 2025 included nurse practitioner (NP) visits monthly from January to July, except March. The medical record lacked evidence of any physician visits to date in 2025.R2's quarterly MDS dated [DATE], indicated R2 admitted [DATE]. R2 had intact cognition with diagnoses that included heart failure, chronic lung disease, diabetes, impaired kidney function, and asthma. R2 required a walk or wheelchair for mobility, substantial/maximum assistance from the staff for mobility, and was unable to walk independently.R2's progress notes dated 9/20/25 at 1:34 a.m., indicated discharge on [DATE]. R2's provider visits records indicated visits by a NP every month in 2025, except February and August, and lacked indication of a physician visits in 2025.R3's admission MDS dated [DATE], indicated admission to the facility on 6/13/25, severe cognitive impairment with diagnoses that included impaired kidney function, malnutrition, asthma for which R3 required oxygen therapy. R3 required a walker or wheelchair for mobility, partial/moderate assistance (helper does less than half the effort), and was able to walk with supervision.R3's provider visits included an initial admission visit on 6/26/25, performed by the NP, and a provider visit on 8/26/25, also performed by the NP. The electronic medical record lacked indication R3 was seen by a physician for the initial assessment, every 30 days after admission, or for an assessment in July by any provider.During an interview on 9/24/25 at 3:05 p.m., the director of nursing (DON) stated the expectation was for residents to see a physician every 60 day after admission, and an NP could alternate visits with the physician. The DON acknowledged, I know we have been having problems with that.During an interview on 9/25/25 at 10:44 a.m., the NP-A stated she emailed the scheduler and DON and informed them physician visits did not occur on schedule, and R1 needed another provider as his provider did not round in the facility. The NP acknowledged R1, R2, and R3 had no physician visits in 2025, and she had performed the admission visit for R3 instead of a physician.During an interview on 9/25/25 at 11:43 a.m., the administrator stated a physician should perform an admission visit and then visit every 30 days for 90 days. A physician then performs visits every 60 days but could alternate those visits with a NP. The administrator stated she was not aware the physician visits were not occurring per regulation.The Physician Visit Schedule policy dated 7/29/25, indicated all individuals will be seen by their physician or physician extender in accordance with the standards set in their regulatory service line.