

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245583	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2025
NAME OF PROVIDER OR SUPPLIER Auburn Home IN Waconia		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0577</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Allow residents to easily view the nursing home's survey results and communicate with advocate agencies.</p> <p>48740</p> <p>Based on observation, interview, and document review, the facility failed to ensure that three years of survey results and the plan of correction were readily accessible to residents or visitors. This deficient practice had the potential to affect all 32 residents currently residing in the facility.</p> <p>Findings include:</p> <p>During an observation on 4/1/25 at 12:00 p.m., the survey results binder was located on a shelf in a sitting area by the front door. The binder contained the last survey results noted from 2/29/24. The binder lacked the plan of correction for the 2/29/24, survey results. The binder lacked the survey results and plan of correction from the 12/1/22, survey.</p> <p>During a co-interview on 4/1/25 at 12:35 p.m., the administrator and director of nursing (DON) confirmed the most recent survey results from 2/29/24, were in the binder without the plan of correction and the plan of correction should have been included in the binder. The administrator and DON verified their process was to keep the most recent survey results in the binder and not the past three years.</p> <p>A policy on survey inspection results was requested and one was not provided.</p>

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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<p>F 0578</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49620</p> <p>Based on observation, interview, and document review, the facility failed to ensure resident advance directives were accurately documented to reflect the resident's current wishes which affected 1 of 16 residents (R29) reviewed for advanced directives. This deficient practice resulted in an immediate jeopardy (IJ) for R29 who would have received cardiopulmonary resuscitation (CPR), contrary to their wishes, in the absence of a pulse or respirations.</p> <p>The IJ began on [DATE], when R29's updated physician's order for life sustaining treatment (POLST) signed on [DATE], identified R29's wishes of do not resuscitate (DNR). The three ring household binder and staff report form identified R29's wishes of CPR. The administrator and director of nursing (DON) were notified of the IJ on [DATE], at 3:35 p.m. The IJ was removed on [DATE], at 12:33 p.m., when the facility had implemented corrective action, however non-compliance remained at the lower scope and severity level of D, isolated with no actual harm but potential to cause more than minimal harm.</p> <p>Findings include:</p> <p>R29's quarterly Minimum Data Set (MDS) dated [DATE], identified R29 had moderately impaired cognition and had diagnoses which included atrial fibrillation (irregular heart rhythm), anemia, coronary artery disease (narrowing or blockage of the coronary arteries). R29 was dependent on staff for activities of daily living (ADLs) which included bed mobility, toileting, and transfers.</p> <p>R29's current POLST signed by family member (FM)-A on [DATE], identified R29's wishes were DNR. The POLST was scanned into his EHR and signed by his medical provider on [DATE].</p> <p>Review of R29's electronic health record (EHR) on [DATE] at 5:29 p.m., identified R9 wanted DNR.</p> <p>R29's care plan lacked documentation on resuscitation status.</p> <p>Review of a facility report form undated, located at the nurses station and carried by each nurse and nursing assistant identified R29 wanted CPR.</p> <p>Review of the household three ring binder located at the nurses station identified R29's POLST signed [DATE], R29 wanted CPR.</p> <p>During an interview on [DATE] at 6:31 p.m., FM-A stated he had signed the POLST on [DATE], identifying that R29's wishes were to be DNR.</p> <p>During an interview on [DATE] at 7:08 p.m., registered nurse (RN)-A indicated in the event a resident did not have a pulse or respirations, she would refer to the report form and would have proceeded accordingly.</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 11:47 a.m., licensed practical nurse (LPN)-A indicated in the event a resident did not have a pulse or respirations, she would refer to the report form located in her pocket and would have proceeded accordingly. LPN-A verified R29's report sheet identified R29 wanted CPR.</p> <p>During an interview on [DATE] at 11:49 a.m., RN-B indicated in the event a resident did not have a pulse or respirations, she would refer to the three ring binder at the nurses desk and would have proceeded accordingly. RN-B verified R29's POLST in the binder identified R29 wanted CPR. RN-B verified there was a discrepancy between R29's EHR and the POLST in the binder and report form.</p> <p>During an interview on [DATE] at 12:18 p.m., RN-C indicated in the event a resident did not have a pulse or respirations, she would refer to the three ring binder at the nurses desk and would have proceeded accordingly. RN-C verified R29's POLST in the binder identified R29 wanted CPR. RN-C verified there was a discrepancy between R29's EHR and the POLST in the binder and report form.</p> <p>During a interview on [DATE] at 2:15 p.m., DON stated a POLST was completed with all residents or resident representatives upon admission and was effective upon admission. DON confirmed there was a discrepancy with R29's EHR, the report form and three ring binder which identified R29 was a full code and did not match his current wishes of being DNR. DON confirmed in the event R29 did not have a pulse or respirations, CPR would have been initiated against R29's wishes. DON indicated she would expect staff to follow the POLST, resident wishes and the facility policy.</p> <p>Review of a facility policy titled Code Status Policy and Procedure, undated, identified the facility would follow a policy regarding a resident's right to request, refuse, and/or discontinue medical treatment and to formulate an advance directive. Identified the POLST would have been documented in the EHR and the household three ring binder. Further identified the code status would have been reviewed with Care Conferences at least quarterly and documented in the medical record.</p> <p>The IJ was removed on [DATE] at 12:33 p.m., when the facility developed and implemented a systemic removal plan which was verified by interview and document review:</p> <ul style="list-style-type: none"> -All residents' records were reviewed to ensure the POLST form and the electronic health records were updated to ensure resident's wishes for advance directives, were accurate on [DATE]. -R29's three ring binder was updated to match the current POLST and the code status for all residents was removed from the report form. -All current licensed staff were educated on the policy for advance directives, updating the POLST, the EHR, and the three ring binder to reflect the resident's wishes on [DATE], as evidenced by the education sent to all nursing staff via email on [DATE] and interviews. -A process was implemented to assure all other nursing staff completed mandatory education prior to the start of their next shift on [DATE], by notification of required education via phone/text. All staff would sign off once education had been completed. -The advance directive policy was reviewed and determined no changes were required. 		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49620</p> <p>Based on interview and document review, the facility failed to provide timely notification to a provider for change in condition related to falls for 1 of 1 resident (R23) reviewed for falls.</p> <p>Findings include:</p> <p>R23's quarterly Minimum Data Set (MDS) dated [DATE], identified R23 had moderately impaired cognition with diagnoses of type two diabetes with chronic kidney disease, anemia, coronary artery disease, arthritis, anxiety, difficulty in walking. Identified R23 required supervision with setup help for bed mobility, transfers, eating and limited assistance of staff for toilet use.</p> <p>R23's care plan dated 9/13/24, identified R23 had a mobility and self care deficit and at risk for falling related to impaired mobility, weakness, and an intellectual disorder. Staff were to monitor/document/report any changes. R23 required supervision or assist to transfer on and off toilet. R23 required supervision with transfers.</p> <p>Review of progress notes from 11/12/24 to 3/31/25, revealed the following:</p> <p>R23's progress note dated 11/12/24 at 2:27 a.m., identified R23's emergency contact was called and informed of R23's fall last night and health status. R23's progress notes lacked documentation of a fall on 11/11/24.</p> <p>R23's progress note dated 1/28/25 at 8:50 a.m., identified R23 was found on the floor laying next to the bed with wheelchair wheels against his back. Staff helped pick R23 up from the floor and took R23 to the bathroom. R23 slipped out of the wheelchair in front of the toilet. Staff picked R23 up and placed R23 on the toilet.</p> <p>R23's progress note dated 2/24/25 at 14:43 p.m., identified R23 was found on the floor in front of the toilet. Staff assisted R23 into wheelchair and then onto the toilet. A follow up note at 4:16 p.m., identified R23's guardian was updated on R23's fall.</p> <p>R23's progress note dated 3/31/25 at 10:18 a.m., R23 was found on the floor in the bathroom. Staff reminded R23 to use the call light before transfers, vitals obtained.</p> <p>R23's progress note dated 3/31/25 at 10:23 a.m., R23 again found sitting on floor in front of toilet. Vitals obtained and diabetic shoes put on for better traction.</p> <p>R23's progress notes lacked documentation the provider had been notified.</p> <p>During an interview on 4/1/25 at 11:47 a.m., licensed practical nurse (LPN)-A stated R23 had a history of falls. LPN-A stated staff were to supervise R23 with toileting and assist as needed. LPN-A stated staff were expected to report a fall, ensure the resident was safe, call provider if suspected injury, complete an incident report and update provider and representative.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/1/25 at 11:49 a.m., RN-B confirmed staff were expected to ensure a resident was safe after a fall, complete an incident/investigation report, update provider and resident representative.</p> <p>A voicemail was left for R23's guardian on 4/2/25 at 2:07 p.m., with no return call.</p> <p>During an interview on 4/2/25 at 2:22 p.m., DON verified R23 had a history of falls. DON confirmed the provider had not been updated on the above falls for R23. DON stated expectations of staff were to ensure resident was safe and not injured after a fall, complete an incident/investigation report and update provider and resident representative. DON confirmed that was important to prevent further falls and ensure the provider and representative were notified.</p> <p>A facility policy titled Accident: Managing Resident Falls, reviewed 7/10/24, identified a fall was defined as an unintentional change in position coming to rest on the ground, floor, or onto the next lower surface. The policy identified a licensed nurse would be notified and evaluate the condition of the resident. Staff were to notify resident representative. Staff were to notify the provider if injury suspected or noted, head strike and on anticoagulants.</p> <p>The policy lacked documentation that a provider would be notified of a fall regardless of injury.</p>

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>48740</p> <p>Based on observation, interview, and document review, the facility failed to ensure grievance forms and procedures were posted in prominent locations throughout the facility for residents and resident representatives to file grievances, and anonymously if desired for 4 of 4 residents (R18, R16, R19, and R7) reviewed for grievances.</p> <p>Findings include:</p> <p>On 3/31/25 at 11:00 a.m., a resident council meeting was held with four residents which included R18, R16, R19, and R7. During the resident council meeting, all four residents indicated they were unaware of how to file a grievance.</p> <p>During an observation on 3/31/25 at 12:00 p.m., the surveyor could not locate grievance forms throughout the facility.</p> <p>During a joint interview on 4/1/25 at 12:35 p.m., the administrator and director of nursing (DON) both confirmed the grievances were kept in the social service office.</p> <p>During an interview on 3/31/25 at 2:38 p.m., social services director (SSD) confirmed there were grievances in her office and was unable to locate grievances that were posted in prominent locations for the residents or resident representatives to file grievances anonymously.</p> <p>During an interview on 4/1/25 at 3:46 p.m., registered nurse (RN)-A confirmed that grievance forms were kept in the social service office and unaware if there were grievances posted in prominent locations for the residents or resident representatives to file grievances anonymously.</p> <p>Review of facility form titled Grievance, Complaint and Non-Retaliation Policy, dated 1/2522, stated If an informal resolution could not be found, the resident would be offered the opportunity to file a formal complaint utilizing a grievance report form. The resident may file a grievance orally to an employee. The employee was to complete the grievance report form with the resident's oral report. The resident could file a grievance anonymously. The grievance would be forwarded to the grievance official for review within a reasonably expected timeframe. The grievance official would work with the resident, the resident's representative, the department manager, and the director of nursing and Social Services to work toward an acceptable solution.</p> <p>The facility Grievance policy updated 1/25/22, lacked documentation on how grievances could be filed anonymously or how to obtain a grievance form other than talking to staff.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49620</p> <p>Based on interview and document review, the facility failed to report a bruise of unknown origin to the State Agency (SA) for 1 of 1 resident (R23) reviewed for falls.</p> <p>Findings include:</p> <p>R23's quarterly Minimum Data Set (MDS) dated [DATE], identified R23 had moderately impaired cognition with diagnoses of type two diabetes with chronic kidney disease, anemia, coronary artery disease, arthritis, anxiety, difficulty in walking. Identified R23 required supervision with setup help for bed mobility, transfers, eating and limited assistance of staff for toilet use.</p> <p>R23's care plan dated 9/13/24, identified R23 had a mobility and self care deficit related to impaired mobility, weakness, and an intellectual disorder. Staff were to monitor/document/report any changes. R23's care plan lacked documentation on skin care and monitoring.</p> <p>Review of R23's progress notes from 11/12/24 to 3/31/25, revealed the following:</p> <p>R23's nursing progress note dated 11/20/24 at 9:35 p.m., stated R23 had a large purple bruise to the right hip/buttock area measuring approximately 20 centimeter (cm) by 15 cm and a smaller red bruise to the left hip measuring approximately five cm by five cm. R23 stated he did not know how he obtained the bruises.</p> <p>R23's nursing progress note dated 1/18/25 at 2:30 p.m., stated R23 had a four cm by ten cm medium purple contusion on lower sacral (buttock) area. R23 stated he did not recall a injury. Origin unknown.</p> <p>An investigation into causative factors and analysis of R23's bruises was requested and was not received.</p> <p>During an interview on 4/1/25 at 11:47 a.m., licensed practical nurse (LPN)-A stated she was unaware of R23 having any bruises. LPN-A stated she would report to the registered nurse (RN) any bruises or injury of unknown origin and update the doctor.</p> <p>During an interview on 4/1/25 at 11:49 a.m., RN-B stated she was unaware of R23 having any bruises. RN-B stated she would report to the director of nursing (DON) any bruises or injury of unknown origin and complete an investigation report.</p> <p>A voicemail was left for R23's guardian on 4/2/25 at 2:07 p.m., with no return call.</p> <p>During an interview on 4/2/25 at 2:22 p.m., DON stated she was unaware of R23 having any bruises. DON confirmed a report to the SA had not been filed and should have been. DON verified the expectation of staff was to complete an incident report, update the doctor and resident representative and follow up with an investigation report. DON stated that was important for resident safety and to ensure no further bruising or deterioration.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/2/25 at 2:37 p.m., administrator stated she was unaware R23 had any bruises.</p> <p>A facility policy on reporting was requested and not received.</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49620</p> <p>Based on interview and document review, the facility failed to investigate a bruise of unknown origin for 1 of 1 resident (R23) reviewed for falls.</p> <p>Findings include:</p> <p>R23's quarterly Minimum Data Set (MDS) dated [DATE], identified R23 had moderately impaired cognition with diagnoses of type two diabetes with chronic kidney disease, anemia, coronary artery disease, arthritis, anxiety, difficulty in walking. Identified R23 required supervision with setup help for bed mobility, transfers, eating and limited assistance of staff for toilet use.</p> <p>R23's care plan dated 9/13/24, identified R23 had a mobility and self care deficit related to impaired mobility, weakness, and an intellectual disorder. Staff were to monitor/document/report any changes. R23's care plan lacked documentation on skin care and monitoring.</p> <p>Review of R23's progress notes from 11/12/24 to 3/31/25, revealed the following:</p> <p>R23's nursing progress note dated 11/20/24 at 9:35 p.m., stated R23 had a large purple bruise to the right hip/buttock area measuring approximately 20 centimeter (cm) by 15 cm and a smaller red bruise to the left hip measuring approximately five cm by five cm. R23 stated he did not know how he obtained the bruises.</p> <p>R23's nursing progress note dated 1/18/25 at 2:30 p.m., stated R23 had a four cm by ten cm medium purple contusion on lower sacral (buttock) area. R23 stated he did not recall a injury. Origin unknown.</p> <p>An investigation into causative factors and analysis of R23's bruises was requested and was not received.</p> <p>During an interview on 4/1/25 at 11:47 a.m., licensed practical nurse (LPN)-A stated she was unaware of R23 having any bruises. LPN-A stated she would report to the registered nurse (RN) any bruises or injury of unknown origin and update the doctor.</p> <p>During an interview on 4/1/25 at 11:49 a.m., RN-B stated she was unaware of R23 having any bruises. RN-B stated she would report to the director of nursing (DON) any bruises or injury of unknown origin and complete an investigation report.</p> <p>A voicemail was left for R23's guardian on 4/2/25 at 2:07 p.m., with no return call.</p> <p>During an interview on 4/2/25 at 2:22 p.m., DON stated she was unaware of R23 having any bruises. DON confirmed an investigation had not been completed. DON verified the expectation of staff was to complete an incident report, update the doctor and resident representative and follow up with an investigation report. DON stated it was important for resident safety and to ensure no further bruising or deterioration occurred.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/2/25 at 2:37 p.m., administrator stated she was unaware R23 had any bruises. Administrator confirmed an investigation had not been completed.</p> <p>A facility policy on reporting and investigation was requested and not received.</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48740</p> <p>Based on observation, interview, and document review, the facility failed to provide assistance with routine grooming care which included facial hair removal for 3 of 3 residents (R7, R12, R3) reviewed for activities of daily living (ADLs) who required assistance with grooming and personal hygiene.</p> <p>Findings include:</p> <p>R7</p> <p>R7's quarterly Minimum Data Set (MDS) dated [DATE], identified R7 as being cognitively intact, and diagnoses which included heart failure, asthma, macular degeneration (vision loss), and dysphagia (difficulty swallowing). R7 required moderate assistance for personal hygiene which included washing and drying face, shaving, and combing hair.</p> <p>R7's care plan revised on 11/4/24, identified R7 requires moderate assistance with personal hygiene.</p> <p>During an observation on 3/31/25 at 4:28 p.m., R7 had .25 centimeters (cm) of hair growth on the cheeks, chin, neck, and upper lips.</p> <p>During an observation on 4/1/25 at 8:11 a.m., R7 was sitting at the breakfast table and continued to have 0.25 cm of hair growth on their face and neck.</p> <p>During an observation on 4/1/25 at 3:50 p.m., R7 was sitting in his room and continued to have 0.25 cm of hair growth on his face and neck.</p> <p>During an interview on 3/31/25 at 4:28 p.m., R7 stated that he would like to be shaved daily.</p> <p>During an interview on 4/1/25 at 4:00 p.m., nursing assistant (NA)-A indicated he was unsure how often R7 would like to be shaved. NA-A reported it was his second shift at the facility and was unaware of how often residents were to be shaved but would assume it would be on a resident's bath day.</p> <p>During an interview on 4/2/25 at 7:18 a.m., NA-B indicated she was unaware of how often R7 would like to be shaved. NA-B indicated residents should have been offered to be shaved on their bath day. NA-B reported it was her first shift at the facility.</p> <p>During an interview on 4/2/25 at 8:01 a.m., NA-C indicated R7 needed assistance with ADLs. NA-C reported R7 was shaved on his bath day and would need to request if he wants to be shaved in addition to once a week.</p> <p>During an interview on 4/1/25 at 4:11 p.m., registered nurse (RN)-A indicated it was her expectation residents were shaved every morning. RN-A verified that R7 had facial hair and should have been offered assistance with grooming.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Auburn Home IN Waconia		STREET ADDRESS, CITY, STATE, ZIP CODE 594 Cherry Drive Waconia, MN 55387	
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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R12</p> <p>R12's significant change MDS dated [DATE], identified R12 as severely cognitively impaired with diagnoses which included dementia, muscle weakness, and peripheral vascular disease (a progressive disorder of the blood vessels). Identified R12 required maximal assistance for personal hygiene which included washing their face, shaving, and combing their hair.</p> <p>R12's care plan revised on 10/11/24, identified R12 required physical assistance with ADLS and mobility on more than a daily basis.</p> <p>During an observation on 3/31/25 at 4:40 p.m., R12 had one cm of hair growth on the face, upper lip, cheeks, and neck.</p> <p>During an observation on 4/1/25 at 8:11 a.m., R12 was sitting at the breakfast table dressed. R12 had not been shaved and continued to have one cm of facial hair on the face and neck.</p> <p>During an observation on 4/1/25 at 3:49 p.m., R12 was in his room and continued to have one cm of facial hair on his face and neck.</p> <p>During an interview on 3/31/25 at 4:40 p.m., R12 indicated he would like to be shaved daily.</p> <p>During an interview on 4/1/25 at 4:00 p.m., nursing assistant (NA)-A indicated he was unaware of how often R12 liked to be shaved. NA-A reported it was his second shift at the facility and was unaware of how often residents were to be shaved but would assume it would be on a resident's bath day.</p> <p>During an interview on 4/2/25 at 7:18 a.m., NA-B indicated she was unaware of how often R12 would like to be shaved. NA-B indicated residents should have been offered the resident's bath day once a week. NA-B reported it was her first shift at the facility.</p> <p>During an interview on 4/1/25 at 4:11 p.m., RN-A indicated it was her expectation residents were shaved every morning. RN-A went into R12's room and verified that R12 had facial hair around one cm. long. R12 told RN-A he wanted his beard shaved today.</p> <p>During an interview on 4/2/25 at 8:01 a.m., NA-C indicated R12 required assistance with ADLs and was shaved on his bath day.</p> <p>R3</p> <p>R3 admission MDS dated [DATE], identified R3 as severely cognitively impaired with a diagnosis that included Parkinson ' s (brain disorder that causes problems with movement, balance, and coordination), dementia, and diabetes (a disease that affects how the body uses blood sugars). Identified R3 as being on hospice and needing supervision or touching assistance for combing hair, shaving, washing face and hands.</p> <p>R3 care plan revised on 2/19/25, identified R3 required supervision or touching assistance for personal care.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 3/31/25 at 3:00 p.m., R3 was sleeping in his room and noted to have two cm of facial hair on cheeks, chin, and neck.</p> <p>During an observation on 4/1/25 at 8:13 a.m., R3 was sitting at the breakfast table sleeping. R3 was dressed and continued to have two cm length of facial hair on face and neck.</p> <p>During an observation on 4/1/25 at 3:27 p.m., R3 was sitting in his bedroom in his wheelchair sleeping. R3 continued to have two cm length of facial hair on the face and neck.</p> <p>During an interview on 3/31/25 at 3:00 p.m., with power of attorney (POA) indicated R3 would like to be shaved daily. R3 shaved daily when living at home and having facial hair would bother him.</p> <p>During an interview on 4/1/25 at 4:00 p.m., nursing assistant (NA)-A indicated he was unaware of how often R3 liked to be shaved. NA-A reported it was his second shift at the facility and was unaware of how often residents were to be shaved but would assume it would be on a resident's bath day.</p> <p>During an interview on 4/2/25 at 7:18 a.m., NA-B indicated she was unaware of how often R3 would like to be shaved. NA-B indicated residents were offered to be shaved on the resident's bath day once a week. NA-B reported it was her first shift at the facility.</p> <p>During an interview on 4/1/25 at 4:11 p.m., RN-A went into R3's room and verified that R12 had facial hair around two cm in length of facial hair.</p> <p>During an interview on 4/2/25 at 8:01 a.m., NA-C indicated R3 required assistance with ADLs and was shaved on his bath day.</p> <p>During an interview on 4/2/25 at 9:02 a.m., director of nursing (DON) indicated residents were shaved on their bath day which was normally once a week. DON was unaware if residents were asked what their preference was with shaving on admission. The DON was unsure if their preference on how often they would like to be shaved was included in the care plan. The DON expectation would be to ask residents what their preference was for shaving and placing the resident's preference in the care plan.</p> <p>A policy for grooming and/or ADL care was requested and non was provided.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49620</p> <p>Based on interview and document review, the facility failed to comprehensively assess and monitor a bruise of unknown origin for 1 of 1 resident (R23) reviewed for falls.</p> <p>Findings include:</p> <p>R23's quarterly Minimum Data Set (MDS) dated [DATE], identified R23 had moderately impaired cognition with diagnoses of type two diabetes with chronic kidney disease, anemia, coronary artery disease, arthritis, anxiety, difficulty in walking. Identified R23 required supervision with setup help for bed mobility, transfers, eating and limited assistance of staff for toilet use.</p> <p>R23's care plan dated 9/13/24, identified R23 had a mobility and self care deficit related to impaired mobility, weakness, and an intellectual disorder. Staff were to monitor/document/report any changes. R23's care plan lacked documentation on skin care and monitoring.</p> <p>Review of R23's progress notes from 11/12/24 to 3/31/25, revealed the following:</p> <p>R23's nursing progress note dated 11/20/24 at 9:35 p.m., stated R23 had a large purple bruise to the right hip/buttock area measuring approximately 20 centimeter (cm) by 15 cm and a smaller red bruise to the left hip measuring approximately five cm by five cm. R23 stated he did not know how he obtained the bruises.</p> <p>R23's nursing progress note dated 1/18/25 at 2:30 p.m., stated R23 had a four cm by ten cm medium purple contusion on lower sacral (buttock) area. R23 stated he did not recall a injury. Origin unknown.</p> <p>R23's nursing progress note dated 3/11/25 at 2:11 p.m., stated R23 had a large bruise on lower back-football size. R23 stated the bruise was from hitting the arm of the wheelchair.</p> <p>R23's progress notes lacked comprehensive assessments and monitoring of the large bruises.</p> <p>An investigation into causative factors and analysis of R23's bruises was requested and was not received.</p> <p>During an interview on 4/1/25 at 11:47 a.m., licensed practical nurse (LPN)-A stated she was unaware of R23 having any bruises. LPN-A stated she would report to the registered nurse (RN) any bruises or injury of unknown origin and update the doctor.</p> <p>During an interview on 4/1/25 at 11:49 a.m., RN-B stated she was unaware of R23 having any bruises. RN-B stated she would report to the director of nursing (DON) any bruises or injury of unknown origin and complete a comprehensive assessment and investigation report. RN-B verified a comprehensive assessment and monitoring of R23's bruises had not been completed.</p> <p>A voicemail was left for R23's guardian on 4/2/25 at 2:07 p.m., with no return call.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/2/25 at 2:22 p.m., DON stated she was unaware of R23 having any bruises. DON verified the expectation of staff was to complete an incident report, update the doctor and resident representative and follow up with an investigation report. DON confirmed a comprehensive assessment and monitoring of R23's bruises had not been completed. DON stated assessments and ongoing monitoring was important for resident safety and to ensure no further bruising or deterioration occurred.</p> <p>A facility policy on comprehensive assessments was requested and not received.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49620</p> <p>Based on observation, interview and document review, the facility failed to provide a comprehensive assessment (fall scene investigation) and a review or adjustment of the current fall prevention interventions to prevent falls for 1 of 1 residents (R23) who had multiple falls within the facility reviewed for falls.</p> <p>Findings include:</p> <p>R23's quarterly Minimum Data Set (MDS) dated [DATE], identified R23 had moderately impaired cognition with diagnoses of type two diabetes with chronic kidney disease, anemia, coronary artery disease, arthritis, anxiety, difficulty in walking. Identified R23 required supervision with setup help for bed mobility, transfers, eating and limited assistance of staff for toilet use.</p> <p>R23's care plan dated 9/13/24, identified R23 had a mobility and self care deficit and at risk for falling related to impaired mobility, weakness, history of falls, and an intellectual disorder. R23 required supervision or assist to transfer on and off toilet. R23 required supervision with transfers. Staff were to monitor/document/report any changes.</p> <p>Review of R23's progress notes from 11/12/24 to 3/31/25, revealed the following:</p> <p>-On 11/7/24 at 8:31 a.m., identified R23 was found on the floor in the bathroom. R23 was reminded to use the call light and wait for assistance. The progress note lacked a fall scene investigation to evaluate the root cause of the fall and implement or change interventions on the plan of care.</p> <p>-On 11/12/24 at 2:27 p.m., identified R23's emergency contact was called and informed of R23's fall last night and health status. R23's progress notes lack documentation of a fall on 11/11/24 and a fall scene investigation to evaluate the root cause of the fall and implement or change interventions on the plan of care.</p> <p>-On 12/17/24 at 6:30 a.m., identified R23 stated he hit his head on the bathroom wall while self transferring from toilet to wheelchair. R23 was sent to the emergency department for evaluation. A follow up progress note on 12/17/24 at 12:03 p.m., identified R23 returned from the emergency department and presented with his usual mental and physical abilities. R23 had a contusion on the left knee and pain in the right hip, received Tylenol. No contusion present on R23's head. The progress note lacked a fall scene investigation to evaluate the root cause of the fall and implement or change interventions on the plan of care.</p> <p>-On 1/5/25 at 5:30 a.m., identified R23 was found on the floor next to the bed. R23 was assisted into the wheelchair and confirmed no injuries. The progress note lacked a fall scene investigation to evaluate the root cause of the fall and implement or change interventions on the plan of care.</p> <p>-On 1/27/25 at 7:04 p.m., identified R23 was on the floor with no injury noted. Staff reminded R23 to call for assistance. The progress note lacked a fall scene investigation to evaluate the root cause of the fall and implement or change interventions on the plan of care.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-On 1/28/25 at 8:50 a.m., identified R23 was found on the floor laying next to the bed with wheelchair wheels against his back. Staff helped pick R23 up from the floor and took R23 to the bathroom. R23 then slipped out of the wheelchair in front of the toilet. Staff picked R23 up and placed R23 on the toilet. The progress note lacked a fall scene investigation to evaluate the root cause of the fall and implement or change interventions on the plan of care.</p> <p>-On 2/24/25 at 14:43 p.m., identified R23 was found on the floor in front of the toilet. Staff assisted R23 into wheelchair and then onto the toilet. The progress note lacked a fall scene investigation to evaluate the root cause of the fall and implement or change interventions on the plan of care.</p> <p>-On 3/6/25 at 14:40 p.m., identified R23 fell in the bathroom for the second time. After the second fall R23 stated his right knee hurt. The progress notes lacked documentation of a first fall on 3/6/25 and further lacked a fall scene investigation to evaluate the root cause of both falls and implement or change interventions on the plan of care.</p> <p>-On 3/31/25 at 10:18 a.m., R23 was found on the floor in the bathroom. Staff reminded R23 to use the call light before transfers, vitals obtained. The progress note lacked a fall scene investigation to evaluate the root cause of the fall and implement or change interventions on the plan of care.</p> <p>-On 3/31/25 at 10:23 a.m., R23 again found sitting on floor in front of toilet. Vitals obtained and diabetic shoes put on for better traction. The progress note lacked a fall scene investigation to evaluate the root cause of the fall.</p> <p>During an interview on 4/1/25 at 11:47 a.m., licensed practical nurse (LPN)-A stated R23 had a history of falls. LPN-A stated staff were to supervise R23 with toileting and assist as needed. LPN-A stated a falls assessment would be completed and an intervention put in place.</p> <p>During an interview on 4/1/25 at 11:49 a.m., RN-B confirmed the above falls occurred for R23. RN-B verified a falls assessment identified as a fall scene investigation was to be completed after each fall to identify the root cause of the fall and an intervention would be implemented on the care plan to prevent further falls. RN-B confirmed a fall scene investigation and new care plan interventions were not completed for the above falls.</p> <p>During an interview on 4/2/25 at 11:51 a.m., physical therapist (PT) verified R23 was receiving therapy for strengthening and falls. PT stated therapy was working with R23 on standing tolerance as R23 had many falls in the bathroom. PT confirmed R23 was not to be independent in the bathroom and to have staff assistance.</p> <p>During an interview on 4/2/25 at 2:22 p.m., DON verified R23 had a history of falls and verified the above falls occurred. DON confirmed a fall scene investigation and care plan interventions were not completed for the above falls. DON stated expectations of staff were to ensure resident was safe and not injured after a fall, complete a falls scene investigation to evaluate and implement or change interventions on the plan of care. DON confirmed that was important to prevent further falls and injury.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A facility policy titled Accident: Managing Resident Falls, reviewed 7/10/24, identified a fall was defined as an unintentional change in position coming to rest on the ground, floor, or onto the next lower surface. The policy identified a licensed nurse would be notified and evaluate the condition of the resident. The staff in conjunction with the interdisciplinary team (IDT), resident and or resident representative would implement the residents plan of care with interventions to reduce the risk of falls. Following a fall, staff would initiate a fall scene investigation to evaluate and implement or change interventions on the plan of care to minimize serious consequences of falling. Immediate interventions implemented or changed to prevent additional falls must be documented on the fall scene investigation form. IDT would review all falls and interventions implemented to further reduce the risk of additional falls.</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49620</p> <p>Based on interview and document review, the facility failed to identify diagnoses or indications for use of medications for 1 of 6 residents (R15) reviewed for unnecessary medications.</p> <p>Findings include:</p> <p>R15's admission Minimum Data Set (MDS) dated [DATE], identified R15 had intact cognition with diagnoses of chronic heart failure, chronic kidney disease, atrial fibrillation. Identified R15 required supervision with setup help for activities of daily living (ADL's).</p> <p>R15's physician's orders and oncology notes were requested and not received.</p> <p>R15's medication administration record (MAR) dated 3/2025, included the following medication but lacked diagnoses or ongoing need for use:</p> <p>-Bactrim DS 800-160 milligrams (mg). Give one tablet by mouth in the morning every Monday, Wednesday, Friday for due to high dose of steroids. Bactrim order initiated 1/15/25.</p> <p>During an interview on on 4/2/25 at 12:58 p.m., RN-B verified R15 had been receiving Bactrim DS 800-160 mg since 1/15/25, and the medication had not been reviewed for unnecessary medications at this time.</p> <p>During an interview on 4/2/25 at 1:48 p.m., pharmacy consultant (PC) stated the facility starting working with the facility three months ago. PC verified R15 was on Bactrim DS 800-160 mg and R15 had been receiving the medication since 1/15/25. PC stated the facility had not established an antibiotic stewardship program with him yet to review antibiotics monthly during his visit. PC confirmed antibiotics would only be used as ordered by a physician and would not be used long term unless indicated.</p> <p>During an interview on 4/2/25 at 1:50 p.m., nurse practitioner (NP) stated Bactrim DS 800-160 mg was not identified on R15's medication list on file at the clinic. NP verified if the Bactrim order was on the current medication file it would have been reviewed at each physician visit to determine if the medication could be discontinued. NP confirmed the expectation of the facility would be to review antibiotics monthly and since R15's steroid use had been decreased over the past few months the Bactrim should have been discontinued. NP verified that was important to review and discontinue unnecessary medications for a resident to prevent unnecessary medication use.</p> <p>During an interview on 4/2/25 at 2:18 p.m., director of nursing (DON) verified R15 was receiving Bactrim DS 800-160 mg three times a week since 1/15/25. DON confirmed R15 was not being monitored or reviewed for unnecessary medication use monthly with the pharmacist or on the facility antibiotic tracking system. The facility did not currently have an infection preventionist to track and monitor unnecessary antibiotic use. DON verified the expectation of the facility was to monitor each resident for unnecessary medications at least monthly to prevent unnecessary medication use.</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A facility policy on medication administration and unnecessary medication use was requested and not received.</p> <p>A facility policy titled Antibiotic Stewardship Program reviewed 2/2020, identified the policy to maintain an antibiotic stewardship program with the mission of promoting the appropriate use of antibiotics to treat infections and reduce possible adverse events associated with antibiotic use. The medical director, nursing team and consultant pharmacist would be responsible for promoting the program.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>37905</p> <p>Based on observation, interview and document review, the facility failed to ensure food items were properly labeled and dated after packaging was opened and were disposed of after the expiration date to prevent cross contamination. In addition, the facility failed to maintain a clean and sanitary kitchen area. This deficient practice had the potential to affect all 32 residents currently residing in the facility.</p> <p>Findings Include:</p> <p>During an initial tour of the kitchen and kitchenettes on 3/31/25 at 2:10 p.m., with dietary manager (DM)-A, the following areas of concern were identified:</p> <ul style="list-style-type: none"> -walk in refrigerator; one large metal pan of fruit crisp, and a tray of fruit cups were covered and not dated. DM-A indicated they should have been dated and applied dated stickers to each item. -stainless steel cupboards had smears, spots and fingerprints inside and outside the doors. The stainless-steel counter below and across the Robot Coupe on the counter multiple various size crumbs were noted. DM-A indicated they did not use the Robot Coupe at this time. -Elm/Island Pantry kitchenette fridge had some multiple irregular shaped spills and crumbs. It also had a sandwich in clear bags dated 3/24, and a clear plastic container covered with clear wrap unmarked dated 1/22. DM-A indicated he thought the container held Caesar dressing, and thought the date marked was the date it was opened and stated he would get rid of that, and DM-A put the sandwich marked 3/24 in the garbage. DM-A stated items should not be kept more than three days. -Elm kitchenette refrigerator had multiple irregular shaped spills and crumbs on shelves and bottom front area inside covering a few inches. One container of Boost supplement opened and not dated. Ten small dishes with pistachio pudding, uncovered and undated. DM-A confirmed the Boost should have been dated when opened, and the puddings should have been covered and dated. DM-A confirmed the above findings and indicated his expectation was for refrigerators to be cleaned daily or at least every other day. -Lake kitchenette refrigerator had a few irregular shaped thick sticky spills and crumbs on top shelf and spills and crumbs on the bottom front area inside. One sandwich in bag undated, a tomato slice in a small sandwich bag with a large amount of pink liquid dated 3/27, and a small sandwich bag of lettuce undated. In addition, a clear plastic container of butter, with written instructions on container to discard 3/24, and an undated, approximately one-half pound of butter, loosely wrapped in its paper wrapping. DM-A threw all items away. DM-A indicated he was working on getting dietary staff trained, and had a meeting scheduled 4/8/25. <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a follow up interview on 4/1/25 at 3:33 p.m., DM-A confirmed the above findings. The stainless-steel cupboards in the kitchen had been cleaned on the outside, but DM-A confirmed they still were not cleaned on the inside, as spots, smears and fingerprints remained. DM-A indicated they should all be wiped down, as well as the refrigerators. DM-A was unable to locate a cleaning schedule for the main kitchen but located a handwritten cleaning schedule for the kitchenettes. DM-A stated it was important to keep the kitchen clean for the integrity of the food and not to invite rodents or pests. DM-A indicated it was important to date foods and to throw items as needed so they were not serving foods that could cause foodborne illness to the residents.</p> <p>Review of the facility policy titled Food Dating And Storage, undated, noted it was to ensure the service of safe potentially hazardous foods/ times and temperatures control for food and safety. The policy instructions included the following:</p> <ul style="list-style-type: none"> -cover with non-absorbent lid or material, use of zip lock baggies or seal food containers. -date the food product the day put into container. -discard any unused food after five days. -food service director or cook in charge will dispose of food after five days. -condiments in such as dressing, mayo, and frosting have a 30 day shelved life when stored in original containers. -Foods that do not have to be disposed of in five days are foods that have use by, Best by or sell by date located on food products. -always check packages for instructions on when to discard. If different from above, follow package guidelines. 		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49620</p> <p>Based on observation, interview and document review, the facility failed to ensure appropriate personal protective equipment (PPE) was worn to prevent the spread of infection for for 1 of 4 residents (R25) observed for enhanced barrier precautions (EBP), (an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities). In addition, the facility failed to ensure safe delivery of beverages during the dining observation. This deficient practice had the potential to affect all 32 residents who resided in the facility.</p> <p>Findings Include:</p> <p>PPE:</p> <p>Review of Centers for Disease Control (CDC) guidance dated 4/1/24, Implementation of PPE Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) indicated Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions (EBP) included: Dressing, Bathing/showering, Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator and wound care: any skin opening requiring a dressing.</p> <p>R25's annual Minimum Data Set (MDS) dated [DATE], identified R25 had intact cognition with diagnoses of dystonia (movement disorder characterized by uncontrollable muscle contractions), neurogenic bladder (nerves that control bladder function are damaged), hypertension (elevated blood pressure), urinary tract infection, anxiety, depression, chronic pain. Identified R25 was independent with bed mobility, transfers and toileting, setup help only for eating and had an indwelling catheter (a hollow, flexible tube inserted through the urethra into the bladder to drain urine into an external collection bag).</p> <p>R25's care plan revised on 1/28/25, identified R25 required an indwelling catheter and staff were to change catheter per physician orders. R25's care plan lacked documentation for use of EBP.</p> <p>R25's annual Care Area Assessment (CAA) dated 1/24/25, identified R25 required an indwelling catheter. R25's CAA lacked documentation for use of EBP.</p> <p>R25's physician order summary report dated 12/13/24, identified R25 had an indwelling catheter that was to be changed by the facility staff on the first Monday of each month.</p> <p>During an observation and interview on 4/1/25 at 9:06 a.m., nursing assistant (NA)-D was in R25's bathroom assisting R25 to get dressed for the day. NA-D washed hands, put on gloves and changed R25's overnight catheter drainage bag to a leg bag for use during the day. NA-D removed her gloves and washed hands. NA-D stated she was unaware R25 was on EBP. Surveyor had NA-D verify R25 had an EBP sign and PPE bin outside of R25's room and that a gown and gloves should have been worn during high contact cares while changing R25's catheter bag and assisting R25 to get dressed. NA-D stated the facility use of EBP was pretty new, unsure of exact date, and NA-D stated she had not had much training on when to use PPE with EBP.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>HAND HYGIENE:</p> <p>During an observation on 4/1/25 at 4:41 p.m., NA-E placed a clothing protector around a resident's neck and chest area and hooked the snap at the back of the residents neck area. NA-E continued this process for two more residents and touched each residents skin while the snaps were hooked around the resident's neck. NA-E proceeded to the kitchenette area, opened the refrigerator, poured five glasses of milk or juice, picked up each glass holding the top rim and delivered the glass to a resident table. NA-E removed a water pitcher from the fridge, poured multiple glasses of water, carried three glasses at a time holding them by the top rim and placed on a table. NA-E poured three glasses of milk, held top rim of each glass and delivered to a resident table. NA-E opened a cupboard door, took out four glasses and set on counter. NA-E poured four more glasses of juice or milk, held onto top rim with her hand and delivered to a resident table.</p> <p>During an interview on 4/1/25 at 4:52 p.m., NA-E confirmed she placed clothing protectors on residents, touched cupboard doors, refrigerator door handle, did not wash her hands, and was unaware she was touching the top rim of the glasses during dining service. NA-E stated she had not received any training on how to handle food and utensils. NA-E stated by touching the top rim of the glasses it could pass germs to residents and they could become ill.</p> <p>During an interview on 4/2/25 at 11:44 a.m., director of nursing (DON) verified R25 was in EBP and had an indwelling catheter. DON confirmed staff had not received EBP and PPE use training except for the information that was posted on the EBP signs on a resident door. DON verified the expectation of staff was to wear PPE gown and gloves when performing high contact cares with a resident to prevent infection and the spread of infection to other residents and staff. In addition, DON verified the expectation of staff was to hold the bottom of a glass and to not touch the top rim where a resident would place their mouth to prevent infection and the spread of germs.</p> <p>A facility policy titled Infection Control: Essential Principles, undated, identified transmission based precautions including: contact, droplet, airborne. The policy lacked documentation on EBP and use of PPE.</p> <p>A facility policy titled Hand Hygiene Policy and Procedure, undated, identified employees were to follow current Centers for Disease Control and Prevention (CDC) hand hygiene recommendations. All employees were responsible for maintaining adequate hand hygiene by adhering to specific infection control practices. Compliance with proper hand hygiene procedures before and after resident contact was an expectation of all healthcare disciplines.</p> <p>A facility policy titled Infection Control: Essential Principles, undated, identified hand hygiene was the single most important practice to reduce the transmission of infections in healthcare settings and was an essential element of standard precautions. In addition, the policy identified hand hygiene would be completed before and after preparing food.</p> <p>A facility policy on handling food and utensils was requested and not received.</p>		

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Implement a program that monitors antibiotic use.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49620</p> <p>Based on interview and document review the facility failed to establish a process for antibiotic review in order to determine appropriate indications for use of an antibiotic for 1 of 1 resident (R15) reviewed for antibiotic use.</p> <p>Findings include:</p> <p>R15's admission Minimum Data Set (MDS) dated [DATE], identified R15 had intact cognition with diagnoses of chronic heart failure, chronic kidney disease, atrial fibrillation. The MDS further identified R15 required supervision with setup help for activities of daily living (ADL's).</p> <p>R15's physician's orders and oncology notes were requested and not received.</p> <p>R15's medication administration record (MAR) dated 3/2025, included the following medication but lacked diagnoses or ongoing need for use:</p> <p>-Bactrim DS 800-160 milligrams (mg). Give one tablet by mouth in the morning every Monday, Wednesday, Friday for due to high dose of steroids. Bactrim order initiated 1/15/25.</p> <p>During an interview on on 4/2/25 at 12:58 p.m., RN-B verified R15 had been receiving Bactrim DS 800-160 mg since 1/15/25 and the medication had not been reviewed for antibiotic stewardship at this time.</p> <p>During an interview on 4/2/25 at 1:48 p.m., pharmacy consultant (PC) stated the facility is new to work with him starting three months ago. PC verified R15 was on Bactrim DS 800-160 mg and R15 had been receiving the medication since 1/15/25. PC stated the facility had not established an antibiotic stewardship program with him yet to review antibiotics monthly during his visit. PC confirmed antibiotics would only be used as ordered by a physician and would not be used long term unless indicated.</p> <p>During an interview on 4/2/25 at 1:50 p.m., nurse practitioner (NP) stated Bactrim DS 800-160 mg was not identified on R15's medication list on file at the clinic. NP verified if the Bactrim order was on the current medication file it would have been reviewed at each physician visit to determine if the medication could be discontinued. NP confirmed the expectation of the facility would be to review antibiotics monthly and since R15's steroid use had been decreased over the past few months the Bactrim should have been discontinued. NP verified that was important to review and discontinue antibiotics for a resident to prevent antibiotic resistance and appropriate antibiotic use.</p> <p>During an interview on 4/2/25 at 2:18 p.m., director of nursing (DON) verified R15 was receiving Bactrim DS 800-160 mg three times a week since 1/15/25. DON confirmed R15 was not being monitored or reviewed for antibiotic stewardship use monthly with the pharmacist or on the facility antibiotic tracking system. The facility did not currently have an infection preventionist (IP) to track and monitor unnecessary antibiotic use. DON verified the expectation of the facility was to monitor each resident receiving antibiotics at least monthly to promote the appropriate use of antibiotics and reduce possible adverse events associated with antibiotic use.</p> <p>(continued on next page)</p>		

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>A facility policy on medication administration and unnecessary medication use was requested and not received.</p> <p>A facility policy titled Antibiotic Stewardship Program reviewed 2/2020, identified the policy to maintain an antibiotic stewardship program with the mission of promoting the appropriate use of antibiotics to treat infections and reduce possible adverse events associated with antibiotic use. The medical director, nursing team and consultant pharmacist would be responsible for promoting the program. The IP was responsible for overseeing the antibiotic stewardship program.</p>

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<p>F 0882</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home.</p> <p>49620</p> <p>Based on interview and document review, the facility failed to ensure the acting infection preventionist (IP) had completed specialized training in infection prevention and control. This deficient practice had the potential to affect all 32 residents residing in the facility.</p> <p>Findings include:</p> <p>During an interview on 4/1/25 at 2:22 p.m., the director of nursing (DON), stated the IP resigned on 2/1/25, and the DON and two nurse managers assumed the infection control role at that time. The DON confirmed the nurse managers and herself were not enrolled in the Centers for Disease Control (CDC) infection preventionist course or any other specialized IP training. The DON added the facility was in the process of hiring a new IP.</p> <p>During an interview on 4/1/25 at 2:30 p.m., RN-B verified she was new to the infection preventionist role and has had no training at this time. RN-B stated the IP role was split between herself, RN-A, and DON.</p> <p>During an interview on 4/1/25 at 2:42 p.m., the administrator stated she was aware the facility currently had no trained infection preventionist.</p> <p>A facility policy titled, Infection Control Policy, revised 2/2023, included the early detection, prevention and management of infections are accomplished through effective oversight of the Infection Prevention and Control program that must include at a minimum, the following elements: To recognize and manage infections at the time of the resident's admission to the facility and throughout the stay; to follow recognized infection prevention and control practice while providing care that includes transmission based precautions and isolation; to provide program oversight including planning, organizing, implementing, operating, and monitoring; to maintain all of the elements of the program and ensuring the facility's interdisciplinary teams is involved in infection prevention and control practices; to develop and revise policies, procedures, and practices that promote consistent adherence to evidence-based infection control practices; to plan organize, implement, operate and maintain all the program elements; to define roles and responsibilities during routine implementation of practice and during unusual occurrences or times of potential risk of spread of infection or outbreak; to define and manage resident and employee health initiatives. The infection Prevention and Control Program components include the establishment of surveillance standards and frequency, the development of the education component including the training in infection prevention and control practices that ensures compliance with facility requirements as well as State and Federal regulations.</p>		