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	06/18/2026

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure physician-ordered monitoring for potential adverse effects related to antipsychotic medication use was completed when orthostatic blood pressures (BP) were not obtained as ordered for 1 of 3 residents (R7) reviewed for unnecessary psychotropic medication use.Findings included:R7's quarterly Minimum Data Set (MDS), dated [DATE], identified R7 had moderately impaired cognition, and diagnoses included chronic diastolic heart failure (a condition where the heart does not fill properly, which may affect blood flow), hypertension (high blood pressure), anxiety disorder, and depression. The MDS further identified R7 received antipsychotic, antianxiety, antidepressant, and diuretic medications.R7's physician orders, print date of 6/18/26 , identified an order for Olanzapine 5 milligrams (mg) by mouth two times daily for psychosis related to depression, with target behaviors including anxiety, apathy, and somatic symptoms (physical symptoms related to emotional distress) such as dizziness and nausea, initiated 4/3/25. R7's physician orders further identified an order to obtain monthly orthostatic blood pressures (lying, sitting, standing blood pressures) due to antianxiety, antidepressant, and antipsychotic medication use, initiated 1/28/25.R7's electronic health record (EHR) from January 2026 through May 2026 lacked evidence orthostatic blood pressures were obtained as ordered. The EHR failed to identify staff completed monitoring to assess R7 for potential medication-related adverse effects, including blood pressure changes associated with antipsychotic medication use.During an interview on 6/18/26 at 7:53 a.m., licensed practical nurse (LPN)-A stated nurses completed orthostatic blood pressures when the task appeared on the treatment administration record (TAR) indicating the monitoring was due.During an interview on 6/18/26 at 9:02 a.m., registered nurse case manager (RN)-A stated orthostatic blood pressures were completed for residents who received antipsychotic medications or had concerns related to orthostatic blood pressures. RN-A reviewed R7's EHR and verified the orthostatic blood pressure order was active, and the order type had not generated a task for nursing staff to document completion. RN-A confirmed orthostatic blood pressures had not been completed since the order was initiated on 1/28/25. RN-A stated monitoring orthostatic blood pressures was important to identify potential adverse effects from medications and blood pressure changes, which could increase a resident's risk for falls.During an interview on 6/18/26 at 9:16 a.m., director of nursing (DON) stated orthostatic blood pressure monitoring was important due to the potential for increased fall risk and adverse effects, including increased confusion and dizziness. DON stated physician-ordered monitoring should have been completed to assess residents for potential medication-related concerns.The facility's Psychotropic Medication Use policy, revised 3/1/25, identified guidelines for the safe and appropriate use of psychotropic medications to ensure effective treatment of mental health conditions while minimizing risks and adverse effects. The policy identified medications used to treat behaviors required a clinical indication and should be used at the lowest possible dose to achieve the desired therapeutic effect. The policy further identified medications used to treat behaviors should be monitored for effectiveness, risks, benefits, and potential adverse consequences.

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure staff implemented infection prevention and control practices when staff failed to wear required personal protective equipment (PPE), including gowns and gloves, during high-contact resident care activities for 1 of 1 resident (R4) reviewed for enhanced barrier precautions (EBP).Findings include:R4's significant change Minimum Data Set (MDS), dated [DATE], identified R4 had intact cognition, and diagnoses included benign prostatic hyperplasia (BPH; enlarged prostate which may affect the ability to empty the bladder), chronic obstructive pulmonary disease (COPD; chronic lung disease that affects breathing), severe protein-calorie malnutrition (lack of adequate nutrition which may affect the body's ability to heal and fight infections), and weakness (decreased strength which may affect mobility and ability to complete daily activities). The MDS further identified R4 required an indwelling urinary catheter (a tube inserted into the bladder to drain urine).R4's care plan, dated 6/18/26 identified R4 required an indwelling urinary catheter and EBP.During observation on 6/16/26 at 12:40 p.m., trained medication aide (TMA)-A and nursing assistant (NA)-A assisted R4 with a transfer from the wheelchair to bed utilizing a mechanical lift. TMA-A and NA-A provided hands-on, physical assistance during the transfer. However, TMA-A and NA-A had not worn gown or gloves while the transfer care was provided.During interview on 6/16/26 at 12:47 p.m., TMA-A stated R4 was on EBP due to an indwelling catheter, and staff were required to wear gowns and gloves when catheter cares were completed. TMA-A stated PPE was not worn during R4's transfer because staff had not provided catheter care.During observation on 6/16/26 at 4:39 p.m., NA-A and NA-B assisted R4 with a transfer utilizing a mechanical lift. NA-A and NA-B provided hands-on assistance during the transfer. NA-A rolled R4 side to side in bed to place the lift sling underneath R4, adjusted the bed, lowered the lift arm, and attached the sling to the lift. NA-A then applied gloves, picked up R4's catheter bag from the bed frame, and attached the catheter bag to the sling. After R4 was transferred into the wheelchair, staff removed the lift sling from underneath R4. However, NA-A and NA-B failed to wear a gown during the transfer, and only NA-A wore gloves while handling R4's catheter bag.During interview on 6/16/26 at 4:47 p.m., NA-A stated R4 was on precautions just for catheter and staff only needed to wear gown and gloves when providing catheter cares, such as emptying the catheter bag.During interview on 6/17/26 at 1:12 p.m., NA-B stated R4 was on precautions related to the catheter and staff were expected to wear gowns and gloves anytime they had contact with R4.During interview on 6/18/26 at 9:05 a.m., registered nurse case manager (RN)-A stated R4 was on EBP and staff were expected to wear a gown and gloves when any hands-on cares were provided. RN-A stated PPE use was important to prevent the spread of infection.During interview on 6/18/26 at 9:17 a.mm., the infection preventionist (IP) stated staff were expected to follow infection prevention practices, including appropriately donning and doffing PPE. The IP stated residents on EBP required staff to wear gowns and gloves during high-contact resident care activities. The IP confirmed transfers required PPE because staff had close physical contact with the resident.During interview on 6/18/26 at 9:20 a.m., the director of nursing (DON) stated staff were expected to wear gowns and gloves whenever they had close contact with residents on EBP. The DON stated personal cares and transfers required gowns and gloves to reduce the risk of spreading infection.The facility's Enhanced Barrier Precautions policy, reviewed 7/9/26, identified the facility would reduce the transmission of Centers for Disease Control and Prevention (CDC)-targeted and epidemiologically important multidrug-resistant organisms (MDROs) through the use of EBP. The policy identified EBP expanded the use of PPE, and required staff to wear gowns and gloves during high-contact resident care activities to reduce the risk of transferring MDROs to staff hands and clothing. The policy identified residents with wounds and/or indwelling medical devices, including urinary catheters, required EBP even if the resident was not known to have an infection or MDRO. The policy further identified gowns (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and gloves were required during high-contact resident care activities, including transferring, providing hygiene, toileting, and urinary catheter device care.