

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245604	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2025
NAME OF PROVIDER OR SUPPLIER Auburn Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 501 Oak Street Chaska, MN 55318	

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 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47083</p> <p>Based on interview and document review, the facility failed to ensure 1 of 3 residents (R1) physician orders were followed for parameters set by the physician. This resulted in actual harm for R1 who became unresponsive and required emergency transport and hospitalization after receiving insulin that should have been held.</p> <p>Findings include:</p> <p>R1's quarterly Minimum Data Set (MDS), dated [DATE], indicated R1 had diagnoses of diabetes mellitus, dementia, and mild cognitive impairment.</p> <p>R1's care plan, dated 9/13/24, directed administer insulin as ordered, monitor for side effects/effectiveness of medication and update provider as needed. Monitor for signs and symptoms of hypoglycemia, follow standing house orders, and update nurse practitioner (NP) as needed.</p> <p>R1's provider orders, dated 3/12/25, directed decrease insulin aspart (rapid-acting insulin used to manage blood sugar in people with diabetes) to 6 units before meals related to Type 2 Diabetes Mellitus with diabetic neuropathy. Hold if blood sugar less than 100 milligrams per deciliter (mg/dl).</p> <p>R1's provider orders, dated 3/20/25, directed hold Novolog (another name for insulin aspart) if blood sugar less than 150 mg/dl.</p> <p>R1's medication administration record (MAR) directed to administer insulin aspart 100 units/milliliter (ml). Inject 6 units subcutaneously before meals. Hold if blood sugar is less than 150 mg/dl. The MAR indicated:</p> <p>On 3/23/25, R1's BS was 137 mg/dl at 7:00 a.m., insulin was administered by RN-A.</p> <p>On 3/28/25, R1's BS was 97 mg/dl at 7:00 a.m., insulin was administered by RN-B and 144 mg/dl at 12:00 p.m., insulin was administered by RN-B.</p> <p>On 3/28/25, R1's BS was 82 mg/dl at 5:00 p.m., and insulin was administered by RN-C.</p> <p>(continued on next page)</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 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A progress note, on 3/26/25 at 10:43 p.m., indicated R 1 was found to have sluggish response upon checking his BS which was found to be 32 mg/dl. R1 was administered glucagon (medication to increase blood sugar levels) 1 milligram (mg) IM (intramuscular) per house standing orders. After 10 minutes, BS was 33 mg/dl, so 9-1-1 was called. R1 was not responsive. Paramedics got BS up to 468 mg/dl, but R1 was still not responsive so he was transferred to the hospital.</p> <p>R1's hospital discharge summary indicated R1 was admitted on [DATE] for generalized weakness, decreased consciousness, hypoglycemia (low blood sugar), bradycardia (slow heart rate), hypokalemia (low potassium), and hypomagnesemia (low magnesium). Hypoglycemia was corrected on 3/28/25 with D50 (dextrose 50% intravenous solution used to restore blood sugar levels). Urinary tract infection (UTI) was diagnosed and treated with antibiotics during hospitalization . R1 was discharged to the facility on [DATE].</p> <p>On 4/2/25, at 12:33 p.m., RN-A stated R1 had a recent order change to hold the insulin if his BS was under 150 mg/dl. RN-A stated she should not have given R1's insulin on 3/23/25 when his BS was 137 mg/dl.</p> <p>On 4/2/25, at 1:15 p.m., RN-B stated he was not informed R1's orders had been recently changed. RN-B stated he should have read the order. RN-B stated he administered 6 units of insulin aspart to R1 for BS readings of 97 and 144 on 3/28/25. RN-B stated he was provided education after the incident, including the need to open another window within the medical chart for additional instructions. RN-B stated the window titled more held the parameters for withholding the insulin and he was unaware of the need to open this section prior to the incident.</p> <p>On 4/2/25, at 1:48 p.m., RN-D stated she was working on 3/28/25, when she was called to help R1 whose BS was 33 mg/dl. RN-D stated she administered glucagon. RN-D stated R1's BS was still 33 mg/dl five minutes after the administration of the medication. She stated she administered another dose of glucagon and glucose gel in his lower lip per the facility's standing orders. RN-D stated R1's BS was 32 mg/dl after five minutes, so 9-1-1 was called. RN-D stated it was important to read the entire medication order and follow it.</p> <p>On 4/2/25, at 3:10 p.m., the director of nursing (DON) stated nurses were expected to read the full medication order. The DON stated the facility was still adjusting to a new electronic medical record system that was implemented 8/2024. The DON stated the system required the nurse to click on more to see scheduling details and parameters.</p> <p>On 4/2/25, at 4:00 p.m., the pharmacist stated if R1 ended up in the hospital with hypoglycemia, after receiving insulin that was ordered to be held for a BS of 82, it should be considered a significant medication error.</p> <p>On 4/2/25, at 4:44 p.m., RN-C (an agency nurse) stated this was his second shift at the facility on 3/28/25. RN-C stated R1's BS was 82 mg/dl and he administered R1's insulin at 5:00 p.m. RN-C stated he did not see the instructions to hold the insulin for a BS less than 150 mg/dl as that was in another section that required him to click on it, labeled more. RN-C stated he was unaware he was expected to click on the section titled more.</p> <p>(continued on next page)</p>

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F 0760 Level of Harm - Actual harm Residents Affected - Few	<p>On 4/2/25, at 4:59 p.m., the NP stated R1's insulin should have been held for a BS of 82. The NP stated the hypoglycemia led to R1 being hospitalized and should be considered a significant medication error.</p> <p>A facility document, Standard Diabetes Mellitus Protocol, undated, directed administer medications as directed.</p> <p>A facility policy, Medications Administered through Certain Routes of Administration, dated 11/15/24, directed subcutaneous injection medications to verify medication order on the MAR; check against physician order.</p>		