STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245604	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Auburn Manor	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)
F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure residents have reasonable access to and privacy in their use of communication methods. Based on interview and document review, the facility failed to ensure resident mail was delivered to residents on Saturdays for 4 of 4 residents (R33, R34, R14, R24) who voiced concerns with mail delivery during Resident Council. This had the potential to affect all residents residing in the facility.On 4/30/26 at 9:33 a.m., a Resident Council meeting was held with four residents from varied areas of the facility. R24 stated mail was not delivered to residents on Saturdays. This was confirmed by R33, R34 and R14. R24 indicated mail delivered by the post office on Saturdays would be left on the receptionist's desk near the front entrance. On Monday morning the receptionist would sort and deliver the mail to residents.During interview on 4/30/26 at 1:09 p.m., Secretary (S)-A stated it was her job Monday through Friday to sort and deliver the mail. SA stated on the weekend it would be the responsibility of the nursing supervisor.During interview on 4/30/26 at 1:22 p/m., registered nurse (RN)-A stated she was unaware collecting and passing mail was part of her responsibilities on the weekends. RN-A then stated she did not have time to deliver mail when she was the only nurse in the building overseeing all staff and residents. RN-A stated she did not have any back up assistance available to her on the weekends.During interview on 4/30/26. At 1:29 p.m., Administrator stated it was the responsibility of the secretary at the front desk to deliver mail. Administrator went on to say occasionally nursing staff would deliver mail on the weekends but not on a regular basis, and mail delivered over the weekend was typically delivered Monday after the front desk staff arrived. Administrator stated it was her expectation mail would be delivered to the residents the same day it was delivered to the facility.An undated policy with no review dated titled Policy of Mail Delivery indicated residents of [facility] have the right to receive and send mail both personal and business in nature and all letters, documents and packages will be delivered 6 (six) days a week, Monday thru Saturday. It is the duty and responsibility of [facility] to see that mail delivered to [facility] is distributed to each resident in a timely fashion.

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to store and label food properly, dispose of undated and expired food items to reduce the risk of foodborne illness. This had the potential to affect all the residents who were provided meals from the kitchen. Findings include:During initial tour and interview of kitchen on 4/27/26 at 1:03 p.m., with Dietary Director (DD) the following was observed inside the walk-in cooler: an opened box of undated chicken stock an opened box of undated turkey stock an approximately 4x4x8 inch metal dish containing sliced carrots lacked an open or use by date,an approximately 4x4x8 inch metal dish with contents identified by DD as pizza sauce lacked an open or used by date.DD stated he was unsure of what the food storage policy stated in regard to leftover food, but he believed all food was to be dated with both an opened on and use by date.During observation of refrigerator in kitchenette by north nursing station on 4/28/26 at 2:48 p.m., the following was observed in the freezer:a loaf of multigrain bread was not sealed, dated and was covered in thick white frost, a gallon bucket of [NAME] vanilla ice cream with a jack o lantern pattern on the outside approximately 1/3 full was covered with a thick layer of white frost on both the inside and outside of the bucket,a gallon bucket of Shoppers Value vanilla ice cream approximately 1/3 full with thick white frost covering the ice cream lacked an open date or use by date.Director of Nursing confirmed the above items lacked proper labeling and should have been discarded.During interview on 4/29/26 at 2:54 p.m., Administrator stated the facilities left over food policy should be followed by all dietary staff. Stated she was unaware of leftovers stored in the kitchen or anywhere else in the facility. Administrator stated dietary staff ?batch cooked' to avoid excess food being made and therefore eliminating the need to store leftovers.A policy titled [facility] Food-No Leftover Food Retention Policy indicated no left-over food was permitted to be saved, stored, cooked, or reused. Any food remaining after service must be discarded immediately.

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F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents a notice of rights, rules, services and charges. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to provide ongoing communication to residents about their rights (e.g., through resident groups) for 4 of 4 residents (R33, R34, R14, R24) who attended the council meetings.Findings include:R33 quarterly minimum data set (MDS) dated [DATE], indicated R33 was cognitively intactR34 quarterly MDS dated [DATE], indicated R34 was cognitively intactR14 quarterly MDS dated [DATE], indicated R14 was cognitively intactR24 quarterly MDS dated [DATE], indicated R24 was cognitively intactResident council meeting minutes dated November 2025 through April 2026, lacked evidence resident rights had been reviewed or included in meeting discussions.During a resident council meeting on 4/30/26 from 9:33 a.m. to 10:48 a.m., R33, R34, R14 and R24 stated they regularly attended resident council meetings and did not recall a time when resident rights had been discussed. All four residents stated they did not know where resident rights were posted in the facility. Resident Right poster hung in a hallway across from the beauty salon.During an interview on 4/30/26 at 1:04 p.m., life enrichment director (LED) stated she was responsible for taking minutes at resident council meetings. LED stated a typical meeting consisted of review of previous months' topics, new residents' concerns and if there were no concerns brought forward, she would go through each department and ask if they had concerns specific to each department. LED stated a representative of the state Ombudsman office had attended resident council and she believed they had discussed resident rights. LED was unable to locate any documentation in resident council notes to support resident rights were discussed. LED stated it was important for residents to understand their rights and the residents of the facility were vulnerable to having others make all decisions for them, their rights violated and were more susceptible to abuse.During an interview on 4/30/26, at 1:49 p.m., Administrator (Admin) stated resident rights were reviewed upon admission. Admin stated if social workers were in attendance for resident council, they would be responsible for reviewing resident rights. Admin stated it was something the facility was working on to standardize recently. Admin stated it was important for residents to know and understand their rights to empower them to self-advocate and went on to state many residents' rights were directly related to how the residents wanted their lives to look.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure 2 of 2 (R33, R34) residents reviewed for dignity, received services in a dignified manner to promote quality of life when staff failed to respond timely to call light and provide toileting assistance resulting in episodes of incontinence.Findings include:R33's admission minimum data set (MDS) dated [DATE], indicated R33 was cognitively intact and had the following diagnoses: history of urinary tract infections (UTI's), depression, generalized weakness and lymphedema (swelling caused by an accumulation of fluid in the tissues).During interview on 4/27/26 at 3:13 p.m., R33 stated she frequently waited for assistance to use the bathroom and at times it could be over an hour. R33 stated it had caused her to become incontinent of both bowel and bladder. She went on to state it doesn't make me feel good. Its degrading. No one wants to sit in their pee or poop.Review of R33's call light logs from 3/29/26 through 4/28/26 indicate R33 had call lights greater than 30 minutes on 26 occasions.R34's admission MDS dated [DATE], indicated R34 was cognitively intact and had the following diagnoses: non-traumatic spinal cord disfunction, peripheral vascular disease (a condition leading to low blood flow to limbs), and personal history of UTI's.During interview on 4/29/26 at 11:51 a.m., R34 stated she needed to use a mechanical lift (a machine to assist in transferring a person from a bed or chair to another location) which required two staff to operate. R34 stated staff frequently had to wait for additional staff assistance and had become incontinent on more than one occasion while waiting. She went on to state she was embarrassed by this and felt like she was being forgotten because she was old.Review of R34's call light logs from 3/29/26 through 4/26/26, indicated R34 had call lights greater than 30 minutes on 14 occasions. During interview on 4/30/26 at 1:22 p.m., Director of Nursing (DON) stated she expected staff to answer call lights as quickly as possible and ideally under 15 minutes. DON confirmed call light logs revealed call lights extending beyond 30, 45 and 60 minutes. DON could not offer an explanation as to why call lights were not being answered faster. DON stated if a resident had to wait an extended amount of time and became incontinent it could have a negative impact on the residents. DON went on to state residents lived at the facility to receive assistance and care. Waiting for a long period of time could result in a resident not receiving the care they needed and could harm them emotionally, holistically and physically. DON stated it was never acceptable if a resident felt embarrassed or humiliated after becoming incontinent because of waiting an extended period for a call light to be answered. A call light policy was requested but not received.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, interview and document review, the facility failed to ensure residents were aware how to file grievances anonymously, for 4 of 4 residents (R33, R34, R24, and R14) reviewed for grievances. Further, the facility failed to maintain a grievance log for a minimum of 3 years. This had the potential to affect all residents residing in the facility.Findings include: During the initial entrance conference on 4/27/26 at 12:11 p.m., Director of Nursing (DON) stated there were no grievances for the previous six months. On 4/30/26 at 9:30 a.m., R33, R34, R24, and R14 stated they were unclear how to file an official grievance, or where to find a grievance form to assure anonymity. All four residents stated they could talk to the Director of Nursing (DON). DON had instructed residents all grievances or concerns were to be handled internally. During interview on 04/30/2026 at 1:22 p.m., DON stated a grievance is any report of a concern a resident feels necessary to discuss about their care or about the facility. DON stated if a resident had a concern they were to bring it to her, the social worker (SW) or any staff and then depending on the concern would determine how it was handled. DON stated a resident could fill out the form or staff could assist them if a resident brought forward a verbal grievance. DON stated residents were encouraged to bring grievances and concerns forward in real time instead of waiting until resident council. She went on to state she verbally followed up with a one-to-one meeting in the resident's room. DON stated the facility did have a process for tracking grievances which included a paper grievance form and a grievance log to be filled out for every reported grievance. DON stated although residents had verbally brought forward concerns, she did not have any copies of grievances, grievance investigations/resolutions, nor did she have a grievance log tracking resident grievance A facility policy titled Grievance, Complaint & Non-Retaliation with a last review date of 1/25/22 indicated the following: Residents are encouraged and supported in bringing their concerns and complaints forward to any [facility] and Services employee. If an informal resolution cannot be found, the resident will be offered the opportunity to file a formal grievance report form. The resident may file a grievance orally to an employee. The employee is to complete the grievance report form with the resident's oral report. The grievance will be forwarded to the grievance official for review within a reasonable expected timeframe. The grievance official will maintain a record of any formal complaints filed. Records will be kept for at least 3 years and will include the dated original complaint, the investigation, and resolution of the compliant. Records will be available for review by the commissioner of health or a designated representative.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure mediations were administered in accordance with physician orders for 1 of 1 residents (R 24) reviewed for medications administration.Findings include: R24's quarterly minimum data set (MDS) dated [DATE] indicated R24 was cognitively intact and had the following diagnoses: Multiple Sclerosis, Hypertension, Neurogenic bladder, Chronic Obstructive Pulmonary Disease and Hyperlipidemia.During interview on 4/30/26 at 10:48 a.m., R24 stated she had not received her scheduled 7:00 a.m. medications. R24's medication administration record on 4/30/26 at 10:52 a.m., revealed blank boxes for R24's scheduled 7:00 a.m. medications indicating they had not been administered. R24 was scheduled but did not receive the following medications:Glucosamine-Chondroitin 500-400mg tablet- 1 tabLisinopril 20mg -1 tabOmeprazole 20mg -1 capsuleMultivitamin tablet -1 tabTrimethoprim 100mg -1 tabFluticasone-Salmeterol Inhalation Aerosol 250-50 MCG/ACT - 1 puffNystatin external powder 100000 u/gmOxybutynin Chloride 5mg -1 tabBaclofen 10mg -1 tabGabapentin 300mg - 3 capsulesDuring an interview on 04/30/2026 1:22 p.m., Director of Nursing (DON) stated medications were expected to be delivered within one hour before or after their scheduled time. DON reviewed R24's medication administration record and confirmed R24 had not received her scheduled medications within the allowable time frame. DON stated it was important for residents to receive medications as scheduled and physician order because the medications are prescribed by a physician to treat specific diagnoses and should be given as the prescriber orders for residents to achieve the best outcomes.Facility policy title Person-centered Medication Pass indicated [NAME] Manor will implement a person-centered medication pass while following manufacturer guidelines as well as applicable State and Federal law and regulations. The policy indicated medications will be scheduled for administration time windows unless clinical contradictions exist or prescribing directions. The policy lacked specific guidelines for medication administration times.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure COVID-19 vaccinations were offered to 1 of 5 residents (R6) reviewed for COVID-19 vaccination status.Findings include: R6's quarterly minimum data set (MDS) dated [DATE], indicated R6 was admitted to the facility on [DATE], and had the following diagnoses: high blood pressure, hyperlipidemia (high levels of fat in the blood), and malnutrition. R6's undated client information vaccination record indicated R6 was overdue for their COVID-19 vaccination. R6's medical record lacked any evidence a COVID-19 vaccination was offered or provided. On 4/30/26 at 10:00 a.m., the Infection preventionist (IP) stated they had just started in this role recently. R6 had been on a list of the previous infection preventionist to be completed, however, was unable to find any supportive documentation it was ever offered or completed. The IP stated they would have expected the vaccination to have been completed within a few days of R6's admission and confirmed it should have already been completed but had not been. On 4/30/26 at 11:01 a.m., the director of nursing (DON) confirmed R6 had not been offered or received the COVID-19 vaccination. Their expectation was it would have been completed within a week of admission. The DON stated importance of supporting the residents with their treatments, preventing any infections, and supporting them in their care choices. The facility COVID Immunization policy dated 4/17/23, indicated [facility] will offer the COVID-19 immunizations and/or boosters to all residents.