



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 9, 2025

Administrator
Aurora On France
6500 France Avenue
Edina, MN 55435

RE: CCN: 245634
Cycle Start Date: May 22, 2025

Dear Administrator:

On May 22, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Alex Warren, Regional Operations Supervisor
Duluth District Office
Health Regulation Division
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55082
Email: Alex.Warren@state.mn.us
Cell: 651-279-5375 Office: 218-302-6186

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by August 22, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by November 22, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:
<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

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A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/10/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245634	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/22/2025
NAME OF PROVIDER OR SUPPLIER AURORA ON FRANCE			STREET ADDRESS, CITY, STATE, ZIP CODE 6500 FRANCE AVENUE EDINA, MN 55435		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
E 000	Initial Comments On 5/19/25-5/22/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000			
F 000	INITIAL COMMENTS On 5/19/25-5/22/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited. : H56344934C (MN00107622), H56344932C (MN00107880), H56344930C (MN00108176), H56344928C (MN00108415), H56344927C (MN00108894), H56344929C (MN00109461), H56344933C (MN00109627), H56344931C (MN00110130), H56344935C MN00111250). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/16/2025

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.

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F 000	Continued From page 1	F 000			
F 550 SS=D	Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained. Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal	F 550			7/8/25

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F 550	Continued From page 2 from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and document review, the facility failed to ensure care was provided to preserve dignity for 2 of 2 residents (R20, R307) who were reviewed for dignity. Findings include: R20: R20's quarterly Minimum Data Set (MDS) dated 2/5/25, indicated R20 was moderately cognitively impaired with the diagnoses of hyperlipidemia, asthma, depression, anxiety, and diabetes. R20's care plan last revised 5/21/25, indicated R20 required an assist of one personal hygiene. The care plan also indicated R20 had impaired vision and instructed staff to make sure R20's glasses were clean and to remind R20 to wear their glasses. During an observation on 5/20/25 at 9:10 a.m., R20 was noted to have several long hairs on their chin. R20 stated they had not noticed they had chin hairs, and stated if they had known they would want the hairs pulled out. R20 stated staff had not asked if the chin hairs bothered them or offered to assist with removing them.			F 550	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in the statement of deficiencies. This Plan of Correction is prepared and/or executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and constitutes the facility's allegation of compliance. 1. Corrective Action: Staff caring for R20 and R307 were re-educated on providing cares in a dignified manner. R20 and R307 were shaven. R307 was discharged on 5/25/25. 2. Corrective Action as it applies to other residents: The dignity policy was reviewed and revised. The Shaving policy was reviewed and revised. All residents with facial hair will be asked if they would like to be shaven. Nursing Staff will be re-educated on how to provide cares in a dignified manner and the shaving policy. 3. Date of Completion: 7/8/25 4. Reoccurrence will be prevented by: Observational audits will be completed to ensure staff are addressing facial hair in		

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F 550	Continued From page 3 During an observation at 5/21/25 on 9:28 a.m., R20 was noted to have several visible chin hairs. During an interview on 5/21/25 at 2:24 p.m., NA-D stated they would not ask a female resident if they wanted their chin hairs removed. Plucking chin hair was not something they did for residents. During an interview on 5/22/25 at 10:40 a.m., NA-E stated they had not had a situation where they identified a female resident with chin hairs, and didn't think offering to pluck chin hairs was something they would do. During an interview on 5/22/25 at 10:42 a.m., NA-F stated it was a personal thing, some women were embarrassed by chin hairs. If they saw a resident with chin hairs, they would ask the resident if they wanted the hairs plucked. During an interview on 5/22/25 at 11:46 a.m., RN-D stated they would expect their staff would offer to take care of chin hair if they noticed a resident had chin hairs growing. It can be embarrassing for some women to have long facial hairs and not know it. Staff should offer to assist residents with chin hairs removal. During an interview on 5/22/25 at 12:31 p.m., the director of nursing (DON) stated dignity is important, and having unwanted facial hair can be a dignity issue for some residents. To be sensitive to all, we have discussed reviewing and putting facial hair preferences on the care plan at the time residents are admitted to the facility. R307:	F 550	alignment with the patients preferences on 3 patients weekly x 1 month, then 1 time weekly for 1 month by the Director of Nursing or designee. Results of the audits will be brought to the QAPI committee meeting for review and further recommendations. 5. The Correction will be monitored by: Director of Nursing or designee		

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F 550	Continued From page 4 R307's admission Minimum Data Assessment (MDS), dated 5/12/2025, indicated R307 had intact cognition, diagnosis for fractures, and needed partial to moderate assistance with personal hygiene. Further, the MDS indicated R307 rated the highest importance to clothing choices, bathing preferences and personal belongings. R307's care plan, dated 5/6/2025, indicated personal preferences for facial hair to be removed to maintain dignity. R307 needed assist of one with bathing, transfers, dressing, and personal hygiene. During an observation and interview on 5/19/25 at 4:19 p.m., R307 had white facial hair covering the entire chin area approximately ¼ inch long. In addition, the area under the nose and above the lip were covered with white hairs approximately ¼ long. R307 stated after a fall at home an ambulance transported her to the hospital, she caught a glimpse facial hair in the mirror and felt embarrassed, would not leave home with facial hair, and stated clearly that facial hair bothered her. During an observation on 5/20/25 at 3:41 p.m., facial hair was still present on R307. During an interview on 5/21/25 at 9:40 a.m., R307 stated facial hair bothers me and asked if it could be seen. If I was at home I would pluck them, I have some tweezers at home. There are a lot of things I don't have here. During an interview on 5/21/25 at 11:55 p.m., registered nurse (RN)-A was unaware of R307's facial hair and would take care of it.			F 550			

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F 550	Continued From page 5 During an interview on 5/21/25 at 11:55 a.m., the director of nursing (DON) stated the facility needs to find a way to address this topic during admission concern over asking female residents about facial hair. The DON was unaware of R307's concerns of facial hair and how it made her feel and suggested possibly getting an electric razor. During an interview on 5/22/25 at 12:15 p.m., the DON stated staff assisted R307 with a disposable razor, R307 told her she had never been shaved before, but it made her feel better. Facility policy, Dignity dated 3/25, identified residents groomed as they wish. Facility policy, AM Cares dated 4/25, identified shaving women and men's facial hair.	F 550			
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement new orders for 1 of 1 resident (R26) with fluid retention and failed to recognize hypertensive blood pressure	F 684			7/8/25
			1. Corrective Action: A nursing order was initiated for R307 to notify nurse of PRN blood pressure medication parameters each shift. MD was notified that patients		

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F 684	Continued From page 6 readings and follow provider orders for as-needed (PRN) blood pressure medication for 1 of 1 resident (R307) reviewed with hypertension. Findings Include: R26: R26's admission MDS (Minimum Data Assessment) dated 5/12/25, indicated R26 was cognitively intact and had diagnoses of cardiorespiratory (heart & lung) conditions, coronary artery disease, heart failure, hypertension, diabetes mellitus, and respiratory failure. R26's care plan dated 5/16/25, indicated diuretic therapy, congestive heart failure intervention such as assessments, monitored labs, documented weights, recorded fluid amounts, and administered cardiac medications. R26's provider orders identified the following: -5/7/25 give furosemide (a medication used to rid the body of excess fluid) 80 milligrams (mg) in the morning, and 40 mg later in the day for heart failure. The order was discontinued on 5/19/25. -5/15/25 a faxed medication order indicated to increase furosemide to 80 mg twice a day (8 a.m. and 4 p.m.). Hold for dizziness/lightheadedness or diarrhea and give furosemide 40 mg instead. R26's medication administration record (MAR) for May 2025, indicated furosemide 80 mg was given in the morning, and furosemide 40 mg was given at 12 p.m. from the 15th through the 18th.			F 684	BP was elevated prior to her fall. MD did not feel it would have contributed to the patients fall. Nurses working with R307 were educated on parameters, timely notification of provider on change in vital signs, and reviewing available PRN medications. R307 discharged from facility on 5/25/25. Provider for R26 was contacted for clarification of Lasix order. New Lasix order received and transcribed. HUC was re-educated on where to place medication clarifications in chart for provider to review. Nurses were re-educated on timely follow up with providers on pending medication clarifications. R26 discharged from facility on 5/21/25. 2. Corrective Action as it applies to other residents: Immediately audited all patients to ensure monitoring of PRN blood pressure parameters was in place. Order Transcription, Change of Condition/Notification policies were reviewed and remain current. Medication Administration-General Guidelines policy was reviewed and revised. Nurses will be re-educated on the policies and procedures. 3. Date of Completion: 7/8/25 4. Reoccurrence will be prevented by: Audits of all PRN antihypertensive medications will be completed to ensure monitoring parameters are in place for any PRN blood pressure medications weekly x 1 month, then 1 time monthly x 1 month. Four random chart audits of physician orders will be completed weekly x 1 month, then 1 time monthly x 1 month by the Director of Nursing or designee.		

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F 684	Continued From page 7 Progress notes for R26 identified the following: -5/15/25 at 10:02 a.m., indicated the provider was made aware of R26's weight gain and would start R26 on 80 mg of furosemide twice a day (BID). -5/21/25 at 4:45 a.m., indicated R26 complained of chest pain and was transported by emergency medical services (EMS) to the hospital. Facility-provided emails dated 5/15/25, identified medical doctor (MD)-A and registered nurse (RN)-A discussed new order for R26. A follow-up email was sent on 5/19/25 at 11:39 a.m., RN-A stated the order sent over on 5/15/25 was missed. During an interview on 5/19/25 at 5:37 p.m., family member (FM)-A stated the provider increased an order for furosemide last week, the order was sent to RN-A, and labs would be checked on Monday, 5/19/25. FM-A stated after the care conference on 5/19/25, MD-A called FM-A back and explained the facility staff didn't enter the new orders for furosemide from last week. During an interview on 5/21/25 at 1:11 p.m., RN-A stated the provider would either give a verbal order or send an email because providers at the hospital use a different computer system. The facility nurses would then enter the order into the electronic medical record (EMR). The main source of communication was through email or verbal communication. The faxed orders went into the resident's paper chart. RN-A confirmed a fax was received on 5/15/25 for R26 to increase the dose of furosemide to 80 mg twice a day and to hold for dizziness, light headiness, or diarrhea	F 684	Results of the audits will be brought to the QAPI committee meeting for review and further recommendations. 5. The Correction will be monitored by: Director of Nursing or designee.		

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F 684	Continued From page 8 and to give furosemide 40 mg instead. During an interview on 5/21/25 at 1:21 p.m., the director of nursing (DON) verified there was no order in R26's EMR updating the furosemide order of 5/15/25. At 3:43 p.m., the DON confirmed the facility did not follow up with the provider on Friday, 5/16/25, for clarification of the medication order received on 5/15/25. During an interview on 5/21/25 at 6:31 p.m., MD-A stated she saw R26 on 5/15/25, and wrote and faxed a new order for furosemide to be increased to 80 mg twice a day. MD-A stated they didn't hear anything back after the original email was sent, so on Monday 5/19/25, after reviewing R26's chart, she emailed RN-A and increased the furosemide orders. MD-A confirmed RN-A didn't attempt to clarify the medication orders on Friday, 5/16/25 or at any time over the weekend. MD-A stated the facility could contact her directly by phone or contact triage regarding order clarification. MD-A stated the furosemide order did delay R26's progress but didn't directly cause harm. MD-A stated the facility had notified her R26 was sent to the hospital with chest pain this morning, and didn't believe the missed medication order and the chest pain were related. A facility policy, Order Transcription dated 10/24, identified verification and communication of orders/transcription and verification: HUC/nurse reviews chart after provider visit to check for any new orders. Orders must be transcribed into the EHR. A second licensed staff member must confirm the order placed in the EHR. Double verification by another nurse is required for medications or critical treatments. Order is faxed	F 684			

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F 684	Continued From page 9 to the pharmacy. Schedule labs or special supplies as needed. Staff uploads any paper copies of order(s) into EHR. Examples: telephone orders, physician written order(s), referral forms, etc. Communication to the care team. R307: R307's admission MDS dated 5/12/25, identified intact cognition and diagnoses of renal insufficiency and hypertension. R307's MDS also indicated a fall prior to admission that resulted in a fracture. R307's care plan dated 5/7/25, identified a problem statement for hypertension and included interventions to administer anti-hypertensive medications, monitor blood pressure readings and any side effects and report these to the provider. R307's medication order dated 5/9/25, identified hydralazine hydrochloride (HCL) oral tablet 25 mg with directions to give as needed for hypertension three times a day as need for blood pressures with the top number (systolic) above 160 and the bottom number (diastolic) over 110. R307's MAR dated May 2025, identified hydralazine HCL 25 mg tablet had never been administered. From 5/9/25 through 5/19/25, R307's blood pressure summary report indicated 10 incidents where the blood pressure readings met criteria to report to the provider and to administer hydralazine HCL 25 mg. R307's progress notes for May 2025 failed to document provider notification of elevated blood pressures or that anti-hypertensive medications			F 684			

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F 684	Continued From page 10 were given. During interview on 5/21/25 at 9:47 a.m., RN-C stated the process for an abnormal blood pressure would be to first check if there was a PRN medication for pain and elevated blood pressures, for example hydralazine. Then her skill set would be used through assessment and reviewed vital signs to determine interventions. The EMR would be reviewed, PRNs could be given, the provider and the nurse manager would be notified and then reassess the patient. During an interview on 5/21/25 at 11:21 a.m., RN-B stated the nurses completed vital signs for their own residents, and if an abnormal vital sign was received, they would use their assessment skills, check the PRN medications, notify the provider and the nurse manager by phone or email. RN-B stated most residents with blood pressure management have PRN orders for hydralazine, it was a very common medication given in the facility. RN-B added once the resident was treated and the plan was completed, a progress note was placed in the residents' chart showing the nurses had followed up on the order with either medication or a different plan the provider wanted to follow. RN-B confirmed nursing assistants didn't check vital signs in this facility, so if there was an elevated blood pressure that was not reported to a provider or medication was not given, then a nurse didn't use their assessment skills. RN-B stated the importance of giving anti-hypertensive medications was elevated blood pressures could result in stroke. During an interview on 5/21/25 at 2:55 p.m., the DON confirmed the completed neurological sheet completed on 5/19/25 documenting the elevated	F 684			

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F 684	Continued From page 11 blood pressures after R307's fall. The DON confirmed the elevated blood pressures should have been documented into the EMR, but confirmed the provider was notified of the fall. The DON stated the RNs involved with caring for R307 at the time of the fall felt the blood pressure and the fall could have been related because medication was not given to reduce the blood pressure. The nurse continued to monitor the blood pressures as they decreased and never administered any medications. The provider agreed with this plan and the details of this conversation were documented. The DON confirmed it would be a medication error for missed doses every time R307 had an elevated blood pressure and there was no provider notification or no anti-hypertensive medication administered. Further, the DON stated her expectation would be if a nurse received an abnormal vital sign, they would notify the provider, provide interventions, and check the PRN orders. During an interview on 5/21/25 at 6:56 p.m., MD-A stated she was notified R307 had a fall on 5/19/25, but staff failed to clarify R307's blood pressure was elevated prior to the fall and was unaware of any other instances of elevated blood pressures prior to 5/19/25 when MD-A assumed R307's care. MD-A confirmed elevated blood pressures could cause headaches, stroke, chest pain, congestive heart failure, but didn't feel the elevated blood pressure and the fall were related in this scenario. Facility policy, Change of Condition/Notification dated 3/25, identified attending physicians/nurse practitioner were to be contacted of all health status changes immediately. Facility policy, Medication Administration dated			F 684			

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F 684	Continued From page 12			F 684			
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure food was properly stored in refrigeration units. In addition the facility failed to ensure dishes were properly air dried prior to stacking for storage. These deficient practices had the potential to impact all residents who consumed facility prepared food. Findings include: During a kitchen tour on 5/19/25 at 2:27 p.m., led			F 812			7/8/25
					1. Corrective Action: Bottom racks were immediately adjusted and moved more than 6 inches above the ground. Boxes in fridge were immediately put on shelving off of the floor. Stacked glasses, food storage containers, and prep pans were immediately ran through the dishwasher again and left to air dry before being stacked. Staff involved were re-educated on Cleaning Dishes policy and Food Storage policy.		

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F 812	Continued From page 13 by the culinary manager (CM) the following were noted: ---The bottom 3 racks on the right of the walk-in freezer were less than 6 inches from the floor of the freezer and held food. The middle rack bottom shelf touched the floor. There was a prep pan of raw whole turkeys on it. The prep pan had a brownish red substance on the bottom of the pan. ---The first-floor fridge had a stack of boxes sitting directly on the fridge floor. The CM stated they had just got a shipment, and the boxes were still being put away. ---On the clean side of dish room there were 18 stacks of plastic glasses that had visible moisture between and in the glasses. The CM stated the glasses had been stacked wet instead of being completely air dried before they were stacked. ---The first-floor food prep area contained several shelves of food storage containers and metal prep table pans. There were multiple stacked 8-quart, 4-quart, and 2-quart food storage containers that appeared to be wet with visible moisture between items. The DM confirmed there was visible moisture inside the storage containers and stated they should not have been stacked until they were completely dry. During an interview on 5/19/25 at 2:46 p.m., dietary aide (DA-A) stated they had stacked the glasses after they came out of the dishwasher to air dry. The CM instructed DA-A not to stack the glasses until they were completely dry. The CM stated letting the glasses air dry was important for infection prevention reasons. During an observation of the walk-in freezer on the first floor on 5/21/25 at 8:34 a.m., it was noted the bottom food shelves on the 3 storage racks	F 812	2. Corrective Action as it applies to other residents: Cleaning Dishes and Food Storage policies were reviewed and remain current. Culinary staff will be re-educated on policy. 3. Date of Completion: 7/8/25 4. Reoccurrence will be prevented by: The Director of Nutrition Services or designee will conduct random audits of food storage areas to ensure nothing is stored withing 6 inches of the ground and random audits of the clean dish room to ensure went dishes are not stacked 3x weekly for 1 month, then 1 time monthly x 1 month. 5. The Correction will be monitored by: Director of Nutrition Services or designee		

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F 812	Continued From page 14 on the right of the freezer were about an inch off the floor, with the second rack's bottom shelf touching the floor on two corners. Two of the bottom shelves contained food. During an interview on 5/21/25 at 8:43 a.m., the CM confirmed three of the rack's shelves in the walk-in freezer were not greater than 6 inches from the bottom of the freezer floor. The DM indicated the racks should not be that close to the floor. The boxes of chicken should not be on the floor of the freezer, they should have been put on a shelf. Ideally when food is delivered it should be put on the shelf by the person that received it. The DM stated pans that held food should be clean and indicated pans in the freezer would be replaced with clean ones. During an observation on 5/21/25 at 8:55 a.m., the in the second-floor dish area there were stack of glasses with visible moisture on both the inside and outside surface areas. In addition, there were cold and hot food storage containers stacked with visible moisture on them. The CM confirmed the glasses and food containers were stacked and wet. The CM stated this was not acceptable, the items needed to air dry before they were stacked for infection control reasons. During a follow-up on 5/21/25 at 9:14 a.m., the CM stated the chicken stacked in the freezer had been there since last evening when it was delivered. The food on the lower shelves in the freezer had all been moved to higher shelves. The facility policy Food Storage dated 2/2024, directed food should be stored at a minimum of six inches off of the floor.	F 812			

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F 812	Continued From page 15	F 812			
F 880 SS=E	The facility policy Cleaning Dishes dated 7/2022, directed dishes should be air dried on racks and should not stacked until they were completely dry. Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be	F 880			7/8/25

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F 880	Continued From page 16 reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure staff adhered to infection control standards including the use of personal protective equipment (PPE) in enhanced barrier precaution (EBP) and contact precaution rooms, as well as failing to properly perform hand washing and	F 880	1. Corrective Action: Audited R208, R23, and R259s charts and precaution signs to ensure appropriate precautions were in place. Provided immediate education to therapy department and all nursing staff working that shift.		

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F 880	Continued From page 17 gloving for 3 of 3 residents (R208, R23, R259) reviewed for infection prevention and control. Findings include: R208: R208's admission Minimum Data Set (MDS) dated 5/12/25, identified intact cognition and diagnoses including non-pressure chronic ulcer of other part of the right foot with necrosis of muscle, gangrene, cellulitis of right lower limb, osteomyelitis, diabetes mellitus, peripheral vascular disease (PVD), chronic kidney disease. The MDS indicated R208 needed moderate assistance of one person for transfers, was taking antibiotics, and had been participating in occupational and physical therapy. R208's provider order dated 5/9/25 included an order for wound care to her right foot. And on 5/6/25, an order for physical and occupational therapy to evaluate and treat as clinically indicated due to an infection on the right foot. R208's care plan dated 5/7/25, identified a problem statement for EBP indefinitely due to right heel diabetic ulcer chronic wound. Interventions included required personal protective equipment (PPE) of gloves and gown prior to the high-contact care activity. High contact care activities included, but were not limited to, dressing, grooming, bathing, transferring, personal hygiene, changing linens, changing briefs or and assisting with toileting. During an observation on 5/20/25 from about 2:30 p.m., to 3:20 p.m. therapy assistant (TA)-E made a few trips from R208's room, with gloves on,			F 880	2. Corrective Action as it applies to other residents: Enhanced Barrier Precautions, Transmission/Isolation Precautions, and Hand Hygiene policies were reviewed and remain current. Staff will be re-educated on the policies. 3. Date of Completion: 7/8/25 4. Reoccurrence will be prevented by: Director of Nursing or designee will conduct random audits of PPE compliance and hand hygiene, two audits three times weekly x one month, then one audit weekly x one month. Results of the audits will be brought to the QAPI committee meeting for review and further recommendations. 5. The Correction will be monitored by: Director of Nursing or designee.		

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F 880	Continued From page 18 down the hall away from R208's room, and then walk back to her room with different items including some free weights, and still wearing gloves. From the hallway, TA-E was observed in the doorway of R208's bathroom, back and forth to her bedroom area, and then transferring R208 out of the bathroom and to her room. TA-E was wearing gloves during these contacts but was not wearing a gown. During an interview on 5/20/25 at 3:28 p.m., TA-E stated he had infection prevention training, through online orientation. TA-E explained he looked at the signs outside the doors to know what kind of precautions were in place, and stated EBP was an infection control measure to keep things from spreading from one person to another. TA-E stated PPE for EBP should be used any time he was touching the person, for activities of daily living, (ADLs), transfers, or bed mobility. TA-E confirmed he was working with R208 today and had transferred her, including in the bathroom after she had gone to the bathroom, and helped her to brush her teeth. TA-E acknowledged he shouldn't be wearing gloves in the hallway unless he was cleaning something up. R23: R23's admission MDS dated 4/21/25, indicated resident was cognitively intact with diagnoses that included recurrent enterocolitis due to Clostridium difficile (bacterial infection that can cause diarrhea), thrombocytopenia (low blood platelet count), sleep apnea, history of falling, and malaise. R23 required a moderate level of assistance for ADLs and was frequently incontinent of bowels.			F 880			

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F 880	Continued From page 19 During observation on 5/19/25 at 2:39 p.m., physical therapy aide (PTA)-A entered R23's room. PTA-A was wearing gloves but was not wearing a personal protective gown. PTA-A adjusted R23's shirt collar and left the room. Signs posted in the hallway outside R23's room indicated resident was on contact precautions. Also observed outside resident room was a small cart containing yellow personal protective gowns, bleach based cleaning wipes, and alcohol based hand sanitizer. During interview on 5/19/25 at 2:40 p.m., PTA-A stated being aware of contact precautions for R23. PTA-A explained being in a hurry and was helping a coworker before the end of the shift. PTA-A did not complete hand washing after leaving R23's room. During observation on 5/19/25 at 2:53 p.m., nursing assistant (NA)-B in R23's room taking resident's breakfast order for 5/20/25. NA-B observed not wearing PPE while in R23's room. NA-B did not complete hand washing after leaving resident's room. During observation on 5/20/25 at 9:19 a.m., NA-A entered R23's room carrying tablet computer. NA-A did not put on any PPE before entering R23's room. NA-A exited resident room and did not do hand hygiene before walking away. During interview on 5/20/25 at 9:20 a.m., NA-A stated R23 was on contact precautions due to having C. diff (Clostridium difficile). NA-A explained going into resident room without personal protective equipment was okay since she did not touch the resident. NA-A did not	F 880			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 880	Continued From page 20 complete hand washing after leaving R23's room. R259: R259's diagnoses list included aftercare following a joint replacement surgery, right artificial knee, heart failure, hypertension, hyperlipidemia, type 2 diabetes, asthma, obstructive sleep apnea, depression, anxiety, and insomnia. During observation on 5/20/25 at 10:06 a.m., signs indicating R259 was on EBP displayed on resident's door observed. NA-C put on gloves and entered R259's room. NA-C changed R259's brief, completed perineal care, and helped resident wash his face and hair. During interview after NA-C left R259's room, NA-C stated not knowing why resident was on EBP. NA-C acknowledged understanding EBP and the need to wear gown and gloves for certain cares. NA-C confirmed wearing gloves and no gown during cares. NA-C further stated he should have worn a gown while giving cares. During an interview on 5/22/25 at 12:39 p.m., the director of nursing (DON) stated she would not expect staff to wear gloves in the hallway unless they were using a hazardous product to clean something. The DON stated this situation was not acceptable, and she also expects staff to wear PPE when precautions are posted. The DON added they have done education to employees on-the-spot regarding precaution types and gloves in the hall. A policy, Hand Hygiene/Glove Use dated 11/8/24, identified: 1. Hand hygiene could be performed with soap			F 880			

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F 880	Continued From page 21 and water or alcohol-based hand rub. When hands were not visibly dirty, AHBR would be the preferred method for hand hygiene in the healthcare setting. The policy gave guidelines when soap and water would be used. 2. Steps for glove use: 3. Don gloves before touching non-intact skin, open wounds or mucus membranes. 4. Change gloves during patient care if the hands will move from a contaminated body site to a clean body site. 5. Perform hand hygiene after doffing gloves and donning a new pair. 6. Remove gloves after contact with a patient and/or the surrounding environment using proper technique to prevent hand contamination. 7. Perform hand hygiene after removing gloves. 8. Do not wear the same pair of gloves for the care of more than one patient. 9. Do not double glove. 10. Do not reuse gloves. 11. Do not wear gloves in the hallway. A policy, Enhanced Barrier Precautions (EBP) dated 1/22/25, identified its purpose was to reduce the risk of infectious agent transmission in healthcare settings. EBP, including gowns and gloves, would be used for chronic wounds, including pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, venous stasis ulcers, indwelling medical devices (catheters, tubes, lines, ostomies). To be used when providing high contact resident care such as dressing, bathing, transferring, changing linens, changing briefs, assisting to the toilet, device care or wound care. A policy, Transmission/Isolation Precautions dated 1/1/25, identified transmission-based precautions were actions implemented in addition			F 880			

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F 880	Continued From page 22 to standard precautions based on the means of transmission. Contact precautions included gown (impermeable to fluid) gloves, and face mask or shield if splashing was likely. These precautions would be used for things such as clostridium difficile. After performing hand hygiene don gown and gloves prior to entering the room. Remove PPE and dispose of in the appropriate container before leaving the resident room. Perform hand hygiene.	F 880			

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 05/21/2025. At the time of this survey, Aurora On France was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18 New Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.			K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/16/2025

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.

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Aurora on France is a 4-story building with a full basement that was determined to be of Type II(222) construction The skilled nursing home on the 2nd floor with customary access on the 1st floor. Each floor is divided into separate smoke compartments and has a horizontal exit dividing the building by a 2-hour fire-rated wall. This facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and	K 000			

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K 000	Continued From page 2 resident rooms that is monitored for automatic fire department notification. There is smoke detection in the resident rooms that are supervised. The 1st floor is memory care with the 3rd, and 4th stories are licensed for assisted living and have a 2-hour fire rated separation. The facility has a capacity of 63 beds and had a census of 56 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000			
K 346 SS=C	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service Where required fire alarm system is out of services for more than four hours in a 24 hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement a fire alarm out-of-service policy per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include:	K 346		7/7/25	
			1. Corrective Action: The Fire Alarm Out of Service policy was updated with the correct contact information for the current State Fire Marshal. 2. Reoccurrence will be prevented by: The Director of Environmental Services will review and revise the policy with any change in State Fire Marshal. 3. Plans to monitor: The Fire Alarm Out of		

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FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 16GR21 Facility ID: 31815 If continuation sheet Page 4 of 5

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K 354	Continued From page 4 Maintenance of Water-Based Fire Protection Systems, section 15.5.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/21/2025 between 09:45 AM and 12:15 PM, it was revealed by a review of available documentation that the fire sprinkler out of service policy that was provided at the time of the survey did not have the correct contact information for the deputy State Fire Marshal that needs to be contacted if the fire sprinkler system goes down for four hours or longer. An interview with the Director of Environmental Services and the Corporate Administrator verified this deficient finding at the time of discovery.	K 354	review and revise the policy with any change in State Fire Marshal. 3. Plans to monitor: The Sprinkler System of Service policy will be reviewed on an annual basis to ensure it remains accurate. 4. The Correction will be monitored by: Director of Environmental Services or designee. 5. Date of Completion: 7/7/25		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 7, 2025

Administrator

Aurora on France

6500 FRANCE AVENUE SOUTH

Edina, MN 55435

RE: CCN: 245634

Cycle Start Date: May 22, 2025

Dear Administrator:

On July 10, 2025, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore, no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in cursive script that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

P.O. Box 64900

Saint Paul, MN 55164-0900

Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us