



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 10, 2026

Administrator
Aurora On France
6500 FRANCE AVENUE
EDINA, MN 55435

RE: CCN:245634

Cycle Start Date: May 28, 2026

Dear Administrator:

On May 28, 2026, 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:

Stefanie Salberg, Regional Operations Supervisor
Metro C District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: stefanie.salberg@state.mn.us
Office: 651-201-4393 Mobile: 651-279-5602

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 28, 2026 (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 28, 2026 (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>

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,

A handwritten signature in black ink, appearing to read "Melissa Poepping". The signature is fluid and cursive, with a large initial "M" and a long, sweeping underline.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



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June 10, 2026

Administrator

Aurora On France

6500 FRANCE AVENUE

EDINA, MN 55435

Re: State Nursing Home Licensing Orders

Event ID: 232C52-H1

Dear Administrator:

The above facility survey was completed on May 28, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the

statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Stefanie Salberg, Regional Operations Supervisor
Metro C District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: stefanie.salberg@state.mn.us
Office: 651-201-4393 Mobile: 651-279-5602

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245634		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/28/2026	
NAME OF PROVIDER OR SUPPLIER Aurora On France				STREET ADDRESS, CITY, STATE, ZIP CODE 6500 FRANCE AVENUE , EDINA, Minnesota, 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	
E0000	Initial Comments		E0000			07/17/2026	
F0000	INITIAL COMMENTS An Emergency Preparedness survey was conducted 5/26/26-5/28/26, at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.475. The facility was in full compliance. On 5/26/26 through 5/28/26, a standard recertification survey was conducted at your facility. In addition, multiple complaint investigations were also completed. Your facility was not compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with no deficiency issued: H56342559C (IQIES 2976631) H56341606C (IQIES 2990926) H56342037C (IQIES 3006237) 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. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.		F0000			07/17/2026	
F0550 SS = D	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.		F0550	Corrective Action: R29's care plan was reviewed and remains current. Patient is total assistance with toileting and incontinent of bowel and bladder. Patient was in agreement with care plan. Re-education provided to resident assistant caring for R29. Education provided to nurse who completed Bowel and Bladder assessment. R29 discharged on 6/5/26. Corrective Action as it applies to other residents: Dignity Policy and Toileting Policy reviewed and		07/17/2026	

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 reverse for further 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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F0550 SS = D	Continued from page 1 §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 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 and record review, the facility failed to promote and maintain dignity for 1 of 3 residents reviewed for dignity (R29) when staff directed a continent resident to "roll over" and have a bowel movement in his brief rather than assessing and implementing toileting interventions consistent with his needs, preferences, and dignity. The facility failed to ensure assessments, care plans, and staff practices provided clear direction regarding R29's toileting status and preferences, despite documentation identifying him as continent of bowel and bladder and his expressed distress regarding having bowel movements in bed. This had the potential to cause psychosocial harm, loss of dignity, and diminished quality of life by failing to respect the resident's autonomy, preferences, and			F0550	Continued from page 1 remains up to date. Education provided to nursing assistants on toileting and dignity. Education provided to nurses on bowel and bladder assessment. Reoccurrence will be prevented by: Weekly audit of bowel & bladder assessment, care plan, and toileting cares provided to be completed by Director of Nursing or designee on 6 residents weekly x4 weeks. Monitoring: Results of audits will be brought to the QAPI committee for review and further recommendations.		07/17/2026

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F0550 SS = D	Continued from page 2 right to receive care in a dignified manner. Findings include: R29's admission Minimum Data Set (MDS), dated 4/30/26, indicated he was admitted to the facility on 4/24/26 and was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15. R29's toileting care plan, initiated 4/24/26 and revised 4/27/26, identified him as totally dependent and directed staff to use a bedpan and/or brief for toileting, clothing management, and hygiene. Additional care plan interventions directed staff to toilet him as requested and as needed and noted he needed assistance with a urinal. A separate incontinence care plan, initiated 4/28/26, directed staff to provide incontinence care according to the bowel and bladder assessments and after incontinence episodes. However, review of a bowel and bladder assessment dated 5/22/26 identified R29 as continent of both bowel and bladder. The assessment contained no documented bowel habits. R29's transferring care plan, initiated 4/24/26 and revised 4/29/26, indicated R28 was "totally dependent" on staff and using a full body mechanical lift for all transfers. R29's Kardex continued to direct staff to provide incontinent care following episodes of incontinence despite the bowel and bladder assessment identifying him as continent. The conflicting assessments and care planning failed to provide clear direction regarding whether R29 was continent and should be assisted to toilet or incontinent and managed through routine brief changes. During interview on 5/26/26 at 2:52 PM, R29 reported he used a urinal but required staff assistance. He stated he had experienced accidents while waiting for staff to respond. He described having a bowel movement in bed as the "most demoralizing part of my whole life." R29 stated staff had never offered or discussed transferring him to a toilet using a mechanical lift despite his awareness and continence. During interview on 5/27/26 at 1:03 PM, nursing assistant (NA)-B stated R29 previously requested a bedpan but currently used a brief and urinal. NA-B stated that on the day of the interview, R29 had a bowel movement in his brief and called for assistance. NA-B stated she told him he would have an easier time having a bowel movement if "he rolled onto his side in bed." NA-B further stated he transferred with a mechanical lift and did not transfer to the toilet. During interview on 5/27/26 at 1:58 PM, registered nurse (RN)-E stated R29 was continent and called staff when he needed a bedpan or urinal. RN-E stated staff positioned the urinal, covered him for privacy, and left the room. RN-E further stated therapy had been completing bathroom transfer training using pivot transfers. RN-E acknowledged a specialty toileting sling was			F0550			07/17/2026

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F0550 SS = D	Continued from page 3 available and could be used to transfer residents to a toilet but stated R29 did not use the sling. The nurse's description of R29 as continent and capable of participating in toileting activities conflicted with care plan and Kardex directions identifying him as incontinent and directing staff to provide routine brief care. During interview on 5/28/26 at 8:18 AM, nurse manager and registered nurse (RN)-F stated that toileting expectations for a continent resident who required a mechanical lift depended on the resident's preferences. RN-F stated residents could use a bedpan or be assisted to a toilet if they wished to get out of bed and staff attempted to respect resident choices. Regarding R29, RN-F stated he preferred a bedpan for bowel movements and a urinal for bladder needs and would use the call light to request assistance. RN-F stated she had offered to assist R29 to the toilet; however, he expressed concerns about safety and believed he needed to improve further before attempting toilet transfers. When informed that a nursing assistant reported telling R29 to roll onto his side and have a bowel movement in his brief, RN-F stated, "We would not say that" and indicated such a statement would be a coachable moment. During interview on 5/28/26 at 9:54 AM, the director of nursing (DON) stated dignified toileting practices included use of a bedpan when needed. The DON stated it was not the standard of care expected by the facility to tell a resident to roll over and have a bowel movement in bed. The DON's statement supported that directing R29 to have a bowel movement in his brief did not align with facility expectations for preserving resident dignity. A facility policy titled Dignity, dated 3/2025, indicated the facility promoted care for residents in a manner that enhanced each resident's dignity and respect in full recognition of their individuality.			F0550			07/17/2026
F0554 SS = D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a			F0554	Corrective Action: R1's medication was removed from bedside. Staff administered meds for R1. Staff caring for R1 were re-educated on self administration expectations. Corrective Action as it applies to other residents: Self Administration of Medications (SAM) policy was reviewed and remains current. An audit of all patients with medication at bedside will be completed to ensure a Self-Administration of Medication assessment has been completed and an order from the provider is in place. Education will be provided to all nurses on SAM requirements and		07/17/2026

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F0554 SS = D	Continued from page 4 self-administration of medications (SAM) assessment was completed to allow resident to safely administer own medications for 1 of 1 (R1) resident observed with medications at bedside. Findings include: R1's comprehensive Minimum Data Set (MDS) dated 5/19/26, indicated R1 was cognitively intact, needed substantial/maximal assistance with toileting hygiene, upper/lower body dressings, bed mobility, transfers, and needed moderate assistance with oral and personal hygiene. R1 was dependent on staff for bathing. R1's diagnosis report dated 5/28/26, indicated diagnosis of pneumonia, acute respiratory failure with hypoxia, hypertensive heart failure, diabetes, anxiety disorder, and chronic low back pain. R1's physician orders dated 5/28/26 included orders for clobetasol propionate external ointment 0.05% (a topical steroid) with directions to apply to labia, distal left wall topically in the evening every Monday, Wednesday, Friday for Lichen Planus (chronic non-contagious inflammatory condition where the immune system mistakenly attacks cells in the skin, hair, nails or genital mucosa). Apply a pea sized amount 3 times weekly. Apply to the inside of the labia and distal left wall of vagina. R1's Medication Administration Record (MAR) dated May 2026, indicated the cream was administered by the staff as ordered. R1's nursing admission assessment dated 5/6/26, included a question about self-administration of medication and the answer was documented as "not applicable". During interview on 5/26/26 at 4:35 p.m., R1 stated she had a vaginal rash, and over a week ago the staff lost her medicated cream (clobetasol). R1 stated first they lost the cream's labeled plastic bag, then they couldn't find the cream. R1 said her husband brought her the clobetasol cream she had at home. During the interview, the clobetasol cream was on top of her nightstand. The clobetasol's box was labeled by a local pharmacy with R1's information. R1 stated she had been applying the cream every day to the affected area, and as needed. During interview on 5/27/26 at 12:41 p.m., registered nurse (RN)-E stated residents can self- administer medications if they are alert and oriented, and after			F0554	Continued from page 4 process. Reoccurrence will be prevented by: Audits of 6 patients to ensure there are no medications unlocked at bedside without an order and Self-Administration of Medication assessment are in place will be completed weekly x4 weeks to be completed by Director of Nursing or designee. Monitoring: Results of audits will be brought to the QAPI committee for review and further recommendations.		07/17/2026

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F0554 SS = D	Continued from page 5 a self-administration of medication (SAM) assessment was completed. RN-E added, the facility also needed a doctor's order. During interview on 5/27/26 at 12:51 p.m., RN-H stated she was not aware R1 had a medicated cream in her room. RN-H looked in the medication cart for the cream and was not there. RN-H retrieved the cream from R1's room and stated she will need a SAM assessment and provider's order to self-administer the medicated cream, and they would need to re-order the medicated cream from our pharmacy. During interview on 5/27/26 at 1:00 p.m., nurse manager RN-F stated before a resident was allowed to self-administer a medication a procedure needed to be followed. RN-F stated a SAM assessment needed to be completed, and the staff needed to obtain a doctor's order for SAM and to be okay to leave medication at bedside. During interview on 5/28/26 at 10:32 a.m., the director of nursing (DON) stated staff needed to screen the resident's cognition, complete a SAM, and contact the provider to obtain an order. DON stated the expectation was no medications will be left at bedside without proper assessment and orders. Facility's policy titled Self Administration of Medications dated 9/2024, indicated the policy of this facility was to establish uniform guidelines concerning the self-administration of drugs in compliance with federal regulations. The policy's procedure indicated a SAM will be completed for any resident requesting to administer any medication without the direct supervision of a nurse. The attending physician's order will be signed and dated prior to self-administration and left at bedside. The medication kept at bedside must be stored in a locked box, attached to something that can't be easily moved. Nurses will educate the resident on the proper use of medications.			F0554			07/17/2026
F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in			F0628	Corrective Action: Bed hold policy was reviewed and revised. A bed hold is to be offered with the ombudsman's contact information for all residents who are transferred to the hospital. Bed holds are to be documented using the bed hold form. R69 discharged from the facility on 3/16/2026. Bed hold form with the ombudsman information and resident appeal rights was reviewed with R51.		07/17/2026

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NAME OF PROVIDER OR SUPPLIER Aurora On France				STREET ADDRESS, CITY, STATE, ZIP CODE 6500 FRANCE AVENUE , EDINA, Minnesota, 55435			
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F0628 SS = D	Continued from page 6 paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.			F0628	Continued from page 6 Corrective Action as it applies to other residents: Audit completed on all residents currently in the hospital for completed bed hold forms. Education provided to social services and nursing on requirement to provide written bed hold form to the patient Reoccurrence will be prevented by: Weekly audit x4 weeks completed by Administrator or designee to ensure bed holds were offered, documented, and form was provided. Monitoring: Results of audits will be brought to the QAPI committee for review and further recommendations.		07/17/2026

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F0628 SS = D	Continued from page 7 (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and			F0628			07/17/2026

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F0628 SS = D	Continued from page 8 (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section.			F0628			07/17/2026

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F0628 SS = D	Continued from page 9 §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to offer a written notice of transfer which included a statement of the resident's appeal rights and the contact information of the Office of the State Long-Term Care Ombudsman. In addition, the facility failed to provide written information on the duration of the bed-hold, and reserve bed payment for 2 of 3 residents (R51, R69) reviewed for hospitalizations. Findings include: R51 R51's admissions Minimum Data Set dated 5/12/26 identified R51 with intact cognition, had no functional impairment, required assistance with toileting, dressing, and showering. In addition, R51 had diagnoses of congestive heart failure, heart disease, arthritis, depression, and chronic lung disease. During record review of R51's electronic medical record (EMR) R51 was hospitalized on 5/13/26 following a fall in his room. He was sent to the hospital and remained until 5/18/26 when he was			F0628			07/17/2026

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F0628 SS = D	Continued from page 10 transferred back to the facility. During interview with registered nurse (RN)-A on 5/28/26 at 6:58 a.m., RN-A stated expectation of staff to print out a face sheet, orders, and medication list to transfer resident to hospital. RN-A stated she was unaware of providing a written transfer and bed hold form. During interview with RN-B on 5/28/26 at 7:09 a.m., RN-B stated expectation of staff to print out a face sheet, orders, and medication list to transfer resident to hospital. RN-B stated nothing was written or signed by the resident on transfer. During interview with R51 on 5/28/26 7:19 a.m., R51 stated he was not offered or provided a verbal or written transfer or bed hold form. During interview with licensed practical nurse (LPN)-A on 5/28/26 at 7:22 a.m., LPN-A stated expectation of staff to print out a face sheet, orders, and medication list to transfer resident to hospital. "We do not have them sign the bedhold or transfer form." R69 R69's admission Minimum Data Set (MDS) assessment dated 3/8/26, indicated R69 had intact cognition with no hallucinations, delusions, or behaviors. R69's progress note dated 3/16/26 at 3:15 p.m., indicated R69 was transferred to the emergency department by ambulance, as R69 had said she was now ready to go. R69's medical record was reviewed, and an indication that a written transfer notice, which included information such as the ombudsman information and the resident's appeal rights, was given on transfer to the hospital was not found. Indication that R69 had been given a written bed-hold notice that included information such as the duration of the state bed-hold policy, the reserve bed payment policy, or the nursing facility's policy regarding bed-hold periods, on transfer to the hospital was not found. During an interview on 5/27/26 at 12:15 p.m., registered nurse (RN)-E stated she sent documents such as the order summary, medication administration record, etc., but did not give a written transfer notice, which included information like			F0628			07/17/2026

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F0628 SS = D	Continued from page 11 ombudsman information and appeal rights, or a written bed hold notice. RN-E stated she believed that social services would follow up with the resident later to see if they would like to hold their bed. During an interview on 5/27/26 at 1:15 p.m., RN-F, the nurse manager for the unit, stated she did not believe they had a process in place to give residents a written notice of transfer, which included information like ombudsman information and appeal rights, or bed hold on transfer to the hospital, although social services did follow up with residents after transfer to see if they would like to hold their bed. During an interview on 5/28/26 at 9:44 a.m., the director of nursing (DON) deferred questions regarding written transfer and bed-hold notices to the assistant administrator (AA). During an interview on 5/28/26 at 9:53 a.m., the AA stated that staff might go through a written bed hold notice with the resident before transfer to the hospital, depending on their responsiveness status. The AA stated otherwise, the social services department would contact the resident or representative at a later time to determine if they would like their bed hold. The AA stated the expected process would be for these conversations to be documented in a progress note, but he wasn't sure how often this was happening. The AA stated he believed the facility had a form that could be given on transfer that included things such as the ombudsman and appeal information but was not sure if staff were giving out this form on transfer to the hospital. The AA stated that if this form was given, he would expect it to be scanned into the electronic medical record, but he did not see it for R69. The facility's Transfer and Discharge from the Facility policy dated 1/22/25, indicated that the "Notice of Transfer or Therapeutic Leave" would be given to the resident or representative at the time of transfer. The policy indicated this would be documented in the resident's record. The policy indicated that if the resident representative was not present at the time of transfer, nursing staff would contact them and notify them of the transfer and clarify the status of the bed hold. The policy indicated that on the first business day following the resident's transfer, social services staff should continue to attempt to reach the representative to clarify the bed-hold status. The policy indicated that social services staff should document the resident's			F0628			07/17/2026

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F0628 SS = D	Continued from page 12 bed hold status in the electronic medical record and should send the notice of transfer, along with the bed hold notice, to the representative for signature. The policy indicated social services would then scan these notices into the electronic health record.			F0628			07/17/2026
F0640 SS = D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly			F0640	Corrective Action: R8 and R42's discharge assessments were submitted to CMS. Corrective Action as it applies to other residents: Audit of all current residents completed to ensure assessments were submitted. MDS Process policy reviewed and revised to ensure submission. Education provided to MDS coordinators on timelines for submission. Reoccurrence will be prevented by: Weekly audit of 6 patient assessments x4 weeks to ensure proper submission to be completed by Director of RAI or designee. Monitoring: Results of audits will be brought to the QAPI committee for review and further recommendations.		07/17/2026

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F0640 SS = D	Continued from page 13 assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure a discharge return anticipated (DRA) Minimum Data Set (MDS) was transmitted for 1 of 3 residents (R42) and a discharge return not anticipated (DRNA) MDS was transmitted for 1 of 1 residents (R8), to the Centers for Medicare and Medicaid (CMS) reviewed for no MDS record in 120 days. Findings include: R42's admission MDS dated 12/11/25, indicated R42 had a "discharge- return anticipated" and it was unplanned. The MDS indicated the assessment was completed but did not indicate the assessment was submitted to CMS. The MDS included under the submit section, "do not submit to CMS". R42's Census listing dated 12/11/25, indicated R42 admitted to the nursing home on 12/8/25, and their status changed to "STOP BILLING" on 12/11/25. R42's progress note dated 12/11/25 at 2:56 a.m., indicated R42 was discharged to the emergency department due to a fall. R8's DRNA MDS dated 1/6/26, indicated R8 had a "discharge- return not anticipated" and it was planned. The MDS indicated the assessment was completed but did not indicate the assessment was submitted to CMS. The MDS included under the submit section, "do not submit to CMS".			F0640			07/17/2026

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F0640 SS = D	Continued from page 14 R8's Census listing dated 1/6/26, indicated R8 admitted to the nursing home on 12/15/25, and their status changed to "STOP BILLING" on 1/6/26. R8's progress note dated 1/6/26 at 12:57 p.m., indicated R8 was discharged with family to an "ILF". During an interview on 5/27/26 at 12:36 p.m., registered nurse (RN)-D, an MDS coordinator, confirmed she had reviewed R42's record and stated that it looked like a DRA assessment had been completed but never sent to CMS. RN-D confirmed she had reviewed R8's record and stated that a DRNA assessment had been completed but also had never been sent to CMS. The facilities MDS/Care Plan Process/Resident Assessment policy dated 10/21/25, indicated that when MDS forms are completed directly on the facility's computer, each assessor signs and dates it, after it is reviewed for accuracy. The policy did not include the expected time frame for submitting DRA/DRNA MDS's to CMS.			F0640			07/17/2026
F0645 SS = D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or			F0645	Corrective Action: a Pre-Admission Screening was completed for R45 on 4/17/26. The PASSAR was forwarded to the lead agency to complete the OBRA Level I. The OBRA Level I was completed on 4/20/26. Corrective Action as it applies to other residents: Audit of all current patients to ensure receipt of their OBRA Level I & Level II (if indicated). PASSAR policy reviewed and remains current. Education provided to admissions and social services regarding receipt of PASSARs prior to admission date. Reoccurrence will be prevented by: Weekly audit of 6 patients x4 weeks by Administrator or designee to ensure all PASSAR documents have been received. Monitoring: Results of audits will be brought to the QAPI committee for review and further recommendations.		07/17/2026

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F0645 SS = D	Continued from page 15 (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.			F0645			07/17/2026

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F0645 SS = D	Continued from page 16 This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure a level I Pre-Admission Screening (PAS) and, if needed, a Level II Pre-Admission Screening and Resident Review (PASARR) was completed to screen for mental health needs for 1 of 1 residents (R45) reviewed for PAS. Findings include: R45's admission Minimum Data Set (MDS) dated 4/17/26, indicated R45 was admitted to the facility on 1/28/25 and had intact cognition. The MDS indicated R45 was diagnosed with anxiety and bipolar disorder. R45's PAS notice dated 4/22/26, indicated a copy of the PAS was included with this notice, but the PAS was not final until the lead agency sent a final determination to the nursing facility. R45's medical record was reviewed and lacked evidence that a final determination from the lead agency had been received. During an interview on 5/27/26 at 2:13 p.m., the admissions coordinator (AC) stated that when a resident was admitted from the hospital, the hospital would complete a PAS, and the screening would then be sent to them. The AC stated that generally she would reach out to the lead agency, and they would sometimes send the final PAS. The AC confirmed that they did see the final PAS from the lead agency, which was "Medica", after reviewing R45's medical record. The AC stated she did not keep documentation on any attempts to reach out to the lead agency for the final PAS. During an interview on 5/28/26 at 9:50 a.m., the administrator stated that admissions was in charge of receiving the PAS and then following up as needed to obtain the final PAS. The facility's PASARR Level I & II policy dated 10/2017, indicated that prior to a resident's admission, the admissions coordinator or designee would ensure the PASARR Level I screening was completed and received. The admissions coordinator or designee would then work with the appropriate community provider to ensure completion of the PASARR level I screening form and verification was			F0645			07/17/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245634		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/28/2026	
NAME OF PROVIDER OR SUPPLIER Aurora On France				STREET ADDRESS, CITY, STATE, ZIP CODE 6500 FRANCE AVENUE , EDINA, Minnesota, 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	
F0645 SS = D	Continued from page 17 received. The policy indicated that the PASARR Level I would be scanned into the resident's medical record.		F0645			07/17/2026	
F0676 SS = D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems.		F0676	Corrective Action: R13's nails were assessed, cleaned, and trimmed. Staff caring for R13 were re-educated on nail care. Corrective Action as it applies to other residents: Nail Care policy was reviewed and remains current. Staff are to evaluate and complete nail care on a resident's bath day and as needed. Whole house audit of current patients nails completed and nails trimmed as identified. Nursing staff will be re-educated on providing nail care. Reoccurrence will be prevented by: Observational audits will be completed to ensure nail care is being completed in alignment with the nail care policy on 6 patients weekly x4 weeks by Director of Nursing or designee. Monitoring: Results of audits will be brought to the QAPI committee for review and further recommendations.		07/17/2026	

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F0676 SS = D	Continued from page 18 This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure routine/as-needed nail trimming and cleaning was completed for 1 of 1 residents (R13) reviewed for nail care who required staff assistance with their activities of daily living (ADLs). Findings include: R13's admission Minimum Data Set (MDS) 4/10/26, indicated R13 had intact cognition and was diagnosed with paraplegia (the partial or complete paralysis of the lower half of the body) and not diabetes. The MDS indicated R13 required setup/clean-up assistance with eating, supervision or touching assistance with oral hygiene and personal hygiene, and was dependent on staff for toileting hygiene, bathing, lower body dressing, and putting on and taking off footwear. R13's care plan dated 4/6/26, indicated a weekly body audit was to be performed. The care plan indicated R13 required setup/clean-up assistance with eating, supervision or touching assistance with oral hygiene and personal hygiene, and was dependent on staff for toileting hygiene, bathing, lower body dressing, and putting on and taking off footwear. R13's Weekly Bath and Skin Sheet dated 5/9/26, 5/17/26, and 5/23/26, included a section titled "Nail Care" with a box checked indicating R13's fingernails were "short and smooth" and did not need trimming. No further completed Weekly Bath and Skin Sheets were found. After reviewing R13's medical record, documentation indicating R13 had received nail care while at the facility before the survey start was not found. During an interview and observation on 5/26/26 at 11:59 a.m., R13 was observed in bed with his fingernails over ¼ of an inch beyond the end of his fingertip with a brown substance underneath the tips of his fingernails. R28 stated he did not have a fingernail clipper and was unsure if he would be able to cut them by himself anyway. R28 stated he had wanted his nails trimmed for a while, but the staff had not offered to assist him with trimming them.			F0676			07/17/2026

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F0676 SS = D	Continued from page 19 During an observation and interview on 5/27/26 at 10:09 a.m., R13 was observed with fingernails over ¼ of an inch beyond the end of his fingertip with a brown substance underneath the tips of his fingernails. R13 stated that no one had offered to help him cut or clean his fingernails. During an interview and observation on 5/27/26 at 1:42 p.m., nursing assistant (NA)-A confirmed he was the aide assisting R13 during the day shift. NA-A stated that R13 required assistance with his activities of daily living, and he did not think R13 would be able to cut his nails by himself. When asked about the appearance of R13's nails, NA-A was unsure. NA-A was observed to enter R13's room and stated R13's nails looked "pretty long", and he thought it was not likely they were short on 5/23/26. NA-A confirmed he had not offered to help R13 complete nail care. During an interview on 5/28/26 at 7:41 a.m., registered nurse (RN)-G stated that the aides should assist the residents with trimming and cleaning their nails on shower days and as needed. RN-G stated that generally, nails would be something the aides would look at, but if the nurse notices that they were long or dirty, they could then delegate nail care to the aide. RN-G stated that if the nurse happened to notice the nail status, they would document this on the weekly bath sheet, but usually the aides would look at a resident's nail status and relay that to the nurse to document. During an interview on 5/28/26 at 9:42 a.m., the director of nursing (DON) stated that nursing staff should be checking resident nail status and trimming and cleaning as needed and on bath days, if indicated. The DON stated that the nurses should be assessing the resident's nail status themselves on bath days to ensure it is accurate. The facility's Care of Nails policy dated 6/20/25, indicated nail care should be completed on bath days and as needed.			F0676			07/17/2026
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care			F0684	Corrective Action: An order for daily weights was obtained from the provider for R84. R84 has been weight daily since 5/28/26. Corrective Action as it applies to other residents: Reviewed current process for all patients with CHF		07/17/2026

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F0684 SS = D	Continued from page 20 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 interview and document review, the facility failed to implement hospital discharge recommendations and facility standing orders for daily weight monitoring for a resident with a primary diagnosis of congestive heart failure (CHF). The facility also failed to assess and implement a low-sodium diet recommendation, failed to monitor for weight changes indicative of fluid retention, and failed to develop a care plan addressing CHF management after the resident's diuretic therapy was placed on hold pending further clinical evaluation for 1 of 1 residents (R84) reviewed for quality of care. Findings include: Findings include: R84's admission Minimum Data Set (MDS) assessment, dated 5/5/26, identified R84 had mild cognitive impairment and a primary diagnosis of chronic congestive heart failure (CHF – a condition where the heart cannot pump blood well often resulting in excess fluid buildup in the body). R84's electronic medical record (EMR) revealed a documented weight of 270 pounds on 5/4/26. R84's hospital Interagency Transfer Form – Physician Orders discharge paperwork dated 5/21/26 indicated R84 was admitted to the hospital on 5/5/26 with a weight of 210 pounds and diagnosis of edema of left upper extremity. R84's Discharge Summary dated 5/21/26 indicated R84 received IV Lasix (furosemide, a medication used to treat fluid retention) during the hospital stay and transitioned to oral Lasix for edema, however, the orders directed R84 should pause taking it “until your doctor or other care provider tells you to start again”. The discharge paperwork included signed orders for daily weights, provider notification for a weight gain of 2 pounds in one day and/or 5 pounds in one week, and a low sodium diet. R84's weight at discharge on 5/21/26 was 169 pounds. R84's facility Orders included “Ok for Standing			F0684	Continued from page 20 and updated to include daily weights. Audit of all patients with CHF diagnosis completed to ensure daily weight orders are in place. Updated Nurse Managers new admission audit. Nurse managers will review hospital discharge summary for any special recommendations related to CHF monitoring along with special diets. If found, the nurse manager will update the provider to get an order for monitoring and ensure transcription of the orders. Education provided to all nurses. Reoccurrence will be prevented by: Weekly audit of new admits with CHF diagnosis to ensure daily weight orders are in place to be completed weekly x 4 weeks by DON or designee. Monitoring: Results of audits will be brought to the QAPI committee for review and further recommendations.		07/17/2026

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F0684 SS = D	Continued from page 21 House Orders” starting 5/21/26. The facility Standing Orders for Nursing Facilities and Skilled Nursing Facilities 2026 signed 2/3/26, included “Daily weights for patients with Heart Failure and call for > 3lb weight gain in 24 hours or 5lbs in one week unless otherwise ordered.” R84’s weight was documented at 153 pounds on 5/23/36. R84’s medical record lacked evidence of daily weight monitoring, instructions for provider notification, and ordered diet following re-admission to the facility. R84’s comprehensive care plan failed to identify congestive heart failure as a focus area and lacked interventions related to CHF management, daily weight monitoring, fluid status monitoring, sodium restriction, or monitoring for signs and symptoms of worsening heart failure. During interview on 5/27/26 at 1:03 p.m., nursing assistant (NA)-B stated staff learned how to care for residents through the Kardex, (which was based off the comprehensive care plan), the nurse, or the manager. NA-B was unable to provide insight regarding specific care provided to R84. During interview on 5/28/26 at 7:51 a.m., licensed practical nurse (LPN)-C stated daily weights would be documented in the Medication Administration Record (MAR). LPN-C stated residents generally received monthly, weekly, or daily weights depending on medications or clinical needs and stated nursing assistants completed weights through nurse delegation. During interview on 5/28/26 at 8:18 a.m., nurse manager and registered nurse (RN)-F stated the hospital discharge recommendations for daily weights and a low-sodium diet should have been followed. RN-F stated daily weights would normally be documented on the Treatment Administration Record (TAR) and stated the dietitian would review dietary recommendations and place them on the resident’s meal ticket. When asked how staff would determine when to restart furosemide without daily weight monitoring, RN-F stated the provider would monitor laboratory values and staff would observe the resident. RN-F acknowledged staff had not routinely monitored R84’s weight as directed by the discharge paperwork. RN-F later stated a diagnosis of CHF would not necessarily require daily weights and stated staff would instead monitor vital signs			F0684			07/17/2026

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F0684 SS = D	Continued from page 22 daily. During interview on 5/28/26 at 9:54 a.m., the Director of Nursing (DON) stated the facility's standing orders included daily weights for residents with CHF; however, not every resident required implementation of those orders. The DON stated nurse managers were responsible for determining which recommendations and interventions should be initiated following admission. The DON further stated unit health coordinators would not necessarily review discharge recommendations unless a specific physician order had been entered and stated nurse managers were responsible for determining which discharge recommendations were most important for each resident. During interview on 5/28/26 at 10:23 a.m., the dietitian stated the facility provided low-sodium diets and followed physician orders for dietary restrictions. A facility policy on Heart Failure monitoring was requested; however, the facility did not have this specific policy.			F0684			07/17/2026
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.			F0755	Corrective Action: R29 and R57's medications were reordered, delivered, and administered. Housestock medications were ordered and delivered. Corrective Action as it applies to other residents: Pharmacy's Ordering and Receiving Medications from the Dispensing Pharmacy policy was reviewed and remains current. Nurses will be re-educated on medication reordering process. Reoccurrence will be prevented by: Audits to ensure medications are available for administration will be completed on 6 residents weekly x 4 weeks. Monitoring: Results of audits will be brought to the QAPI committee for review and further recommendations.		07/17/2026

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F0755 SS = D	Continued from page 23 §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to provide pharmaceutical services that ensured medications were available to meet residents' needs for 2 of 5 residents reviewed for medication administration (R29 and R57). This deficient practice resulted in multiple prescribed medications being unavailable for administration and created the potential for residents to miss ordered medications or receive doses that differed from the physician's prescribed regimen. Findings include: R29's admission Minimum Data Set (MDS), dated 4/30/26, indicated he was admitted to the facility on 4/24/26 and was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15. R57's admission Minimum Data Set (MDS), dated 5/7/26, indicated he was admitted to the facility on 5/1/26 and was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 13. During observation and interview on 05/27/2026 at 8:01 a.m., RN-E conducted a medication pass for R29 and identified four medications that were unavailable for administration, including ginkgo biloba, a multivitamin with minerals, vitamin B12, and vitamin E. RN-E checked the medication cart and available house stock but was unable to locate the medications. RN-E stated she would need to fax and call the pharmacy to ensure the medications were delivered that day and reported medications generally should be reordered when the supply reached the last row of a medication card or when there was still a few days of the medication left giving time for the medication to be delivered before it ran out. RN-E stated the assistant administrator, who was also filling the supplier role, reordered house stock medications. RN-E further stated she would need to notify the provider regarding the unavailable medications because they were vitamins and not considered urgent. RN-E stated, "So I am missing 4 different med, that's a lot." During observation and interview on 05/28/2026 at 7:51 a.m., LPN-C conducted a medication pass for R57 and was unable to locate cyclosporine ophthalmic drops ordered for administration. LPN-C stated the			F0755			07/17/2026

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F0755 SS = D	Continued from page 24 medication should have been reordered when the supply reached the last package of eye drops and reported she would administer the resident's other medications and continue searching because mornings were busy. During the same medication pass, LPN-C identified that the resident's ordered losartan 75 mg was unavailable and only losartan 50 mg was present. LPN-C stated the resident should have had one 50 mg tablet and one 25 mg tablet available for administration and reported she had called the pharmacy twice during her previous shift on Tuesday regarding the missing medication. During a follow-up interview on 05/28/2026 at 9:50 a.m., LPN-C stated she obtained a one-time order from the nurse practitioner to administer losartan 50 mg in place of the prescribed losartan 75 mg because the ordered dose was unavailable. LPN-C stated staff were not permitted to split tablets to achieve the ordered dose. During interview on 05/28/2026 at 8:18 a.m., the nurse manager and RN-F stated the expectation was for the nurse administering the medication to reorder it when approximately seven days of supply remained. RN-F stated staff were expected to fax refill requests to the pharmacy and follow up by telephone to confirm receipt of the fax. RN-F stated pharmacy staff sometimes responded that refill requests were submitted too early and at other times reported they had not received the faxed request. RN-F stated nurses did not always have time to call the pharmacy to verify receipt of refill requests and acknowledged, "it should not be that way," but "life happens." A pharmacy policy titled Ordering and Receiving Medication from the Dispensing Pharmacy, dated 9/10/24, indicated refill request of current medications should be placed 5-7 days before the current supply runs out to ensure to gaps in medication administration.			F0755			07/17/2026

Minnesota Department of Health

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20000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 5/26/26 through 5/28/26, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). In addition, several complaint investigations were completed. Your facility was found not in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. In addition to the recertification survey, the following complaint was reviewed with no licensing orders			20000			07/17/2026

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/28/2026	
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20000	Continued from page 1 issued: H56342559C (IQIES 2976631) H56364160C (IQIES 2990926) H56342037C (IQIES 3006237) MDH is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met asevidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.		20000			07/17/2026	
20915	Rehab - ADLs CFR(s): MN Rule 4658.0525 Subp. 6 A Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and		20915	Corrected		07/17/2026	

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NAME OF PROVIDER OR SUPPLIER Aurora On France				STREET ADDRESS, CITY, STATE, ZIP CODE 6500 FRANCE AVENUE , EDINA, Minnesota, 55435			
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20915	Continued from page 2 services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure routine/as-needed nail trimming and cleaning was completed for 1 of 1 residents (R13) reviewed for nail care who required staff assistance with their activities of daily living (ADLs). Findings include: R13's admission Minimum Data Set (MDS) 4/10/26, indicated R13 had intact cognition and was diagnosed with paraplegia (the partial or complete paralysis of the lower half of the body) and not diabetes. The MDS indicated R13 required setup/clean-up assistance with eating, supervision or touching assistance with oral hygiene and personal hygiene, and was dependent on staff for toileting hygiene, bathing, lower body dressing, and putting on and taking off footwear. R13's care plan dated 4/6/26, indicated a weekly body audit was to be performed. The care plan indicated R13 required setup/clean-up assistance with eating, supervision or touching assistance with oral hygiene and personal hygiene, and was dependent on staff for toileting hygiene, bathing, lower body dressing, and putting on and taking off footwear. R13's Weekly Bath and Skin Sheet dated 5/9/26, 5/17/26, and 5/23/26, included a section titled "Nail Care" with a box checked indicating R13's fingernails were "short and smooth" and did not			20915			07/17/2026

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20915	Continued from page 3 need trimming. No further completed Weekly Bath and Skin Sheets were found. After reviewing R13's medical record, documentation indicating R13 had received nail care while at the facility before the survey start was not found. During an interview and observation on 5/26/26 at 11:59 a.m., R13 was observed in bed with his fingernails over ¼ of an inch beyond the end of his fingertip with a brown substance underneath the tips of his fingernails. R28 stated he did not have a fingernail clipper and was unsure if he would be able to cut them by himself anyway. R28 stated he had wanted his nails trimmed for a while, but the staff had not offered to assist him with trimming them. During an observation and interview on 5/27/26 at 10:09 a.m., R13 was observed with fingernails over ¼ of an inch beyond the end of his fingertip with a brown substance underneath the tips of his fingernails. R13 stated that no one had offered to help him cut or clean his fingernails. During an interview and observation on 5/27/26 at 1:42 p.m., nursing assistant (NA)-A confirmed he was the aide assisting R13 during the day shift. NA-A stated that R13 required assistance with his activities of daily living, and he did not think R13 would be able to cut his nails by himself. When asked about the appearance of R13's nails, NA-A was unsure. NA-A was observed to enter R13's room and stated R13's nails looked "pretty long", and he thought it was not likely they were short on 5/23/26. NA-A confirmed he had not offered to help R13 complete nail care. During an interview on 5/28/26 at 7:41 a.m., registered nurse (RN)-G stated that the aides should assist the residents with trimming and cleaning their nails on shower days and as needed. RN-G stated that generally, nails would be something the aides would look at, but if the nurse notices that they were long or dirty, they could then delegate nail care to the aide. RN-G stated that if the nurse happened to notice the nail status, they would document this on the weekly bath sheet, but usually the aides would look at a resident's nail status and relay that to the nurse to document. During an interview on 5/28/26 at 9:42 a.m., the			20915			07/17/2026

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20915	Continued from page 4 director of nursing (DON) stated that nursing staff should be checking resident nail status and trimming and cleaning as needed and on bath days, if indicated. The DON stated that the nurses should be assessing the resident's nail status themselves on bath days to ensure it is accurate. The facility's Care of Nails policy dated 6/20/25, indicated nail care should be completed on bath days and as needed. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could educate responsible staff to provide care to residents' requiring assistance from facility staff, based on residents' comprehensively assessed needs. The DON or designee could conduct audits of resident cares to ensure their personal hygiene needs are met consistently. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.		20915			07/17/2026	
21550	Adminiatration of Medications; Pharmacy Serv. CFR(s): MN Rule 4658.1325 Subp. 1 Subpart 1. Pharmacy services. A nursing home must arrange for the provision of pharmacy services. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to provide pharmaceutical services that ensured medications were available to meet residents' needs for 2 of 5 residents reviewed for medication administration (R29 and R57). This deficient practice resulted in multiple prescribed medications being unavailable for administration and created the potential for residents to miss ordered medications or receive doses that differed from the physician's prescribed regimen. Findings include: R29's admission Minimum Data Set (MDS), dated 4/30/26, indicated he was admitted to the facility on 4/24/26 and was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15. R57's admission Minimum Data Set (MDS), dated 5/7/26, indicated he was admitted to the facility on 5/1/26 and was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 13. During observation and interview on 05/27/2026 at 8:01 a.m., RN-E conducted a medication pass for R29 and identified four medications that were		21550	Corrected		07/17/2026	

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21550	Continued from page 5 unavailable for administration, including ginkgo biloba, a multivitamin with minerals, vitamin B12, and vitamin E. RN-E checked the medication cart and available house stock but was unable to locate the medications. RN-E stated she would need to fax and call the pharmacy to ensure the medications were delivered that day and reported medications generally should be reordered when the supply reached the last row of a medication card or when there was still a few days of the medication left giving time for the medication to be delivered before it ran out. RN-E stated the assistant administrator, who was also filling the supplier role, reordered house stock medications. RN-E further stated she would need to notify the provider regarding the unavailable medications because they were vitamins and not considered urgent. RN-E stated, "So I am missing 4 different med, that's a lot." During observation and interview on 05/28/2026 at 7:51 a.m., LPN-C conducted a medication pass for R57 and was unable to locate cyclosporine ophthalmic drops ordered for administration. LPN-C stated the medication should have been reordered when the supply reached the last package of eye drops and reported she would administer the resident's other medications and continue searching because mornings were busy. During the same medication pass, LPN-C identified that the resident's ordered losartan 75 mg was unavailable and only losartan 50 mg was present. LPN-C stated the resident should have had one 50 mg tablet and one 25 mg tablet available for administration and reported she had called the pharmacy twice during her previous shift on Tuesday regarding the missing medication. During a follow-up interview on 05/28/2026 at 9:50 a.m., LPN-C stated she obtained a one-time order from the nurse practitioner to administer losartan 50 mg in place of the prescribed losartan 75 mg because the ordered dose was unavailable. LPN-C stated staff were not permitted to split tablets to achieve the ordered dose. During interview on 05/28/2026 at 8:18 a.m., the nurse manager and RN-F stated the expectation was for the nurse administering the medication to reorder it when approximately seven days of supply remained. RN-F stated staff were expected to fax refill requests to the pharmacy and follow up by telephone to confirm receipt of the fax. RN-F stated pharmacy staff sometimes responded that refill requests were submitted too early and at other times reported they had not received the faxed request. RN-F stated nurses did not always have time to call the pharmacy to verify receipt of refill requests and acknowledged, "it should not be that way," but "life			21550			07/17/2026

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21550	Continued from page 6 happens.” A pharmacy policy titled Ordering and Receiving Medication from the Dispensing Pharmacy, dated 9/10/24, indicated refill request of current medications should be placed 5-7 days before the current supply runs out to ensure to gaps in medication administration. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review policies and procedures for medication administration to include how medication is ordered timely to prevent missed medication doses. Staff could be educated on the need to order medications timely and the proper procedure for medication ordering. The DON or designee could review all current resident medication orders to ensure accuracy and audit new medication orders per recommendation from the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time. Those results could be taken back to the QAPI committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.		21550			07/17/2026	
21565	Administration of Medications Self Admin CFR(s): MN Rule 4658.1325 Subp. 4 Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a self-administration of medications (SAM) assessment was completed to allow resident to safely administer own medications for 1 of 1 (R1) resident observed with medications at bedside. Findings include: R1’s comprehensive Minimum Data Set (MDS) dated 5/19/26, indicated R1 was cognitively intact, needed substantial/maximal assistance with toileting		21565	Corrected		07/17/2026	

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21565	Continued from page 7 hygiene, upper/lower body dressings, bed mobility, transfers, and needed moderate assistance with oral and personal hygiene. R1 was dependent on staff for bathing. R1's diagnosis report dated 5/28/26, indicated diagnosis of pneumonia, acute respiratory failure with hypoxia, hypertensive heart failure, diabetes, anxiety disorder, and chronic low back pain. R1's physician orders dated 5/28/26 included orders for clobetasol propionate external ointment 0.05% (a topical steroid) with directions to apply to labia, distal left wall topically in the evening every Monday, Wednesday, Friday for Lichen Planus (chronic non-contagious inflammatory condition where the immune system mistakenly attacks cells in the skin, hair, nails or genital mucosa). Apply a pea sized amount 3 times weekly. Apply to the inside of the labia and distal left wall of vagina. R1's Medication Administration Record (MAR) dated May 2026, indicated the cream was administered by the staff as ordered. R1's nursing admission assessment dated 5/6/26, included a question about self-administration of medication and the answer was documented as "not applicable". During interview on 5/26/26 at 4:35 p.m., R1 stated she had a vaginal rash, and over a week ago the staff lost her medicated cream (clobetasol). R1 stated first they lost the cream's labeled plastic bag, then they couldn't find the cream. R1 said her husband brought her the clobetasol cream she had at home. During the interview, the clobetasol cream was on top of her nightstand. The clobetasol's box was labeled by a local pharmacy with R1's information. R1 stated she had been applying the cream every day to the affected area, and as needed. During interview on 5/27/26 at 12:41 p.m., registered nurse (RN)-E stated residents can self- administer medications if they are alert and oriented, and after a self-administration of medication (SAM) assessment was completed. RN-E added, the facility also needed a doctor's order. During interview on 5/27/26 at 12:51 p.m., RN-H stated she was not aware R1 had a medicated cream in her room. RN-H looked in the medication cart for the cream and was not there. RN-H retrieved the cream from R1's room and stated she will need a SAM assessment and provider's order to			21565			07/17/2026

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21565	Continued from page 8 self-administer the medicated cream, and they would need to re-order the medicated cream from our pharmacy. During interview on 5/27/26 at 1:00 p.m., nurse manager RN-F stated before a resident was allowed to self-administer a medication a procedure needed to be followed. RN-F stated a SAM assessment needed to be completed, and the staff needed to obtain a doctor’s order for SAM and to be okay to leave medication at bedside. During interview on 5/28/26 at 10:32 a.m., the director of nursing (DON) stated staff needed to screen the resident's cognition, complete a SAM, and contact the provider to obtain an order. DON stated the expectation was no medications will be left at bedside without proper assessment and orders. Facility's policy titled Self Administration of Medications dated 9/2024, indicated the policy of this facility was to establish uniform guidelines concerning the self-administration of drugs in compliance with federal regulations. The policy's procedure indicated a SAM will be completed for any resident requesting to administer any medication without the direct supervision of a nurse. The attending physician's order will be signed and dated prior to self-administration and left at bedside. The medication kept at bedside must be stored in a locked box, attached to something that can't be easily moved. Nurses will educate the resident on the proper use of medications. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for self administration of medications. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure medications were correctly administered. The quality assurance committee could monitor these measures to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days		21565			07/17/2026	
21925	Patients & Residents of HC Fac.Bill of Rights CFR(s): MN St. Statute 144.651 Subd. 29		21925	Corrected		07/17/2026	

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21925	Continued from page 9 Subd. 29. Transfers and discharges. Residents shall not be arbitrarily transferred or discharged. Residents must be notified, in writing, of the proposed discharge or transfer and its justification no later than 30 days before discharge from the facility and seven days before transfer to another room within the facility. This notice shall include the resident's right to contest the proposed action, with the address and telephone number of the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12). The resident, informed of this right, may choose to relocate before the notice period ends. The notice period may be shortened in situations outside the facility's control, such as a determination by utilization review, the accommodation of newly-admitted residents, a change in the resident's medical or treatment program, the resident's own or another resident's welfare, or nonpayment for stay unless prohibited by the public program or programs paying for the resident's care, as documented in the medical record. Facilities shall make a reasonable effort to accommodate new residents without disrupting room assignments. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to offer a written notice of transfer which included a statement of the resident's appeal rights and the contact information of the Office of the State Long-Term Care Ombudsman. In addition, the facility failed to provide written information on the duration of the bed-hold, and reserve bed payment for 2 of 3 residents (R51, R69) reviewed for hospitalizations. Findings include: R51 R51's admissions Minimum Data Set dated 5/12/26 identified R51 with intact cognition, had no functional impairment, required assistance with toileting, dressing, and showering. In addition, R51 had diagnoses of congestive heart failure, heart disease, arthritis, depression, and chronic lung disease. During record review of R51's electronic medical record (EMR) R51 was hospitalized on 5/13/26 following a fall in his room. He was sent to the hospital and remained until 5/18/26 when he was transferred back to the facility. During interview with registered nurse (RN)-A on		21925			07/17/2026	

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21925	Continued from page 10 5/28/26 at 6:58 a.m., RN-A stated expectation of staff to print out a face sheet, orders, and medication list to transfer resident to hospital. RN-A stated she was unaware of providing a written transfer and bed hold form. During interview with RN-B on 5/28/26 at 7:09 a.m., RN-B stated expectation of staff to print out a face sheet, orders, and medication list to transfer resident to hospital. RN-B stated nothing was written or signed by the resident on transfer. During interview with R51 on 5/28/26 7:19 a.m., R51 stated he was not offered or provided a verbal or written transfer or bed hold form. During interview with licensed practical nurse (LPN)-A on 5/28/26 at 7:22 a.m., LPN-A stated expectation of staff to print out a face sheet, orders, and medication list to transfer resident to hospital. "We do not have them sign the bedhold or transfer form." R69 R69's admission Minimum Data Set (MDS) assessment dated 3/8/26, indicated R69 had intact cognition with no hallucinations, delusions, or behaviors. R69's progress note dated 3/16/26 at 3:15 p.m., indicated R69 was transferred to the emergency department by ambulance, as R69 had said she was now ready to go. R69's medical record was reviewed, and an indication that a written transfer notice, which included information such as the ombudsman information and the resident's appeal rights, was given on transfer to the hospital was not found. Indication that R69 had been given a written bed-hold notice that included information such as the duration of the state bed-hold policy, the reserve bed payment policy, or the nursing facility's policy regarding bed-hold periods, on transfer to the hospital was not found. During an interview on 5/27/26 at 12:15 p.m., registered nurse (RN)-E stated she sent documents such as the order summary, medication administration record, etc., but did not give a written transfer notice, which included information like ombudsman information and appeal rights, or a written bed hold notice. RN-E stated she believed that social services would follow up with the resident later to see if they would like to hold their			21925			07/17/2026

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21925	Continued from page 11 bed. During an interview on 5/27/26 at 1:15 p.m., RN-F, the nurse manager for the unit, stated she did not believe they had a process in place to give residents a written notice of transfer, which included information like ombudsman information and appeal rights, or bed hold on transfer to the hospital, although social services did follow up with residents after transfer to see if they would like to hold their bed. During an interview on 5/28/26 at 9:44 a.m., the director of nursing (DON) deferred questions regarding written transfer and bed-hold notices to the assistant administrator (AA). During an interview on 5/28/26 at 9:53 a.m., the AA stated that staff might go through a written bed hold notice with the resident before transfer to the hospital, depending on their responsiveness status. The AA stated otherwise, the social services department would contact the resident or representative at a later time to determine if they would like their bed hold. The AA stated the expected process would be for these conversations to be documented in a progress note, but he wasn't sure how often this was happening. The AA stated he believed the facility had a form that could be given on transfer that included things such as the ombudsman and appeal information but was not sure if staff were giving out this form on transfer to the hospital. The AA stated that if this form was given, he would expect it to be scanned into the electronic medical record, but he did not see it for R69. The facility's Transfer and Discharge from the Facility policy dated 1/22/25, indicated that the “Notice of Transfer or Therapeutic Leave” would be given to the resident or representative at the time of transfer. The policy indicated this would be documented in the resident's record. The policy indicated that if the resident representative was not present at the time of transfer, nursing staff would contact them and notify them of the transfer and clarify the status of the bed hold. The policy indicated that on the first business day following the resident's transfer, social services staff should continue to attempt to reach the representative to clarify the bed-hold status. The policy indicated that social services staff should document the resident's bed hold status in the electronic medical record and should send the notice of transfer, along with the bed hold notice, to the representative for signature. The policy indicated social services would then scan		21925			07/17/2026	

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21925	Continued from page 12 these notices into the electronic health record. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could review and/or develop policy and procedures that written notification was provided to the resident and their representative before a transfer. The facility could educate staff on these policies and audit periodically. The results of these audits will be reviewed by the quality assessment committee to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days			21925			07/17/2026

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NAME OF PROVIDER OR SUPPLIER Aurora On France				STREET ADDRESS, CITY, STATE, ZIP CODE 6500 FRANCE AVENUE , EDINA, Minnesota, 55435			
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K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 05/26/2026. 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 Occupancies 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. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145			K0000			07/03/2026

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 reverse for further 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245634		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - AURORA ON ... B. WING		(X3) DATE SURVEY COMPLETED 05/26/2026	
NAME OF PROVIDER OR SUPPLIER Aurora On France				STREET ADDRESS, CITY, STATE, ZIP CODE 6500 FRANCE AVENUE , EDINA, Minnesota, 55435			
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K0000 Bldg. 01	Continued from page 1 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 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 59 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are			K0000			07/03/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245634		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - AURORA ON ... B. WING		(X3) DATE SURVEY COMPLETED 05/26/2026	
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K0000 Bldg. 01	Continued from page 2 NOT MET as evidenced by:			K0000			07/03/2026
K0761 SS = F Bldg. 01	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, sections 5.2.1 and 5.2.4.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/26/2026 between 11:30 AM and 01:30 PM, it was revealed by a review of available documentation that the fire door inspection report provided at the time of the survey did not specify the items that were inspected. An interview with the Administrator and Maintenance verified this deficient finding at the time of discovery.			K0761	Annual 13 point fire door inspection was completed. Education provided to Maintenance staff on annual fire door inspection. Administrator will audit the completion of the fire door inspection and Director of Maintenance or designee will review annually. Results of audit will be reported to QAPI committee for review and further recommendations.		07/03/2026
K0918 SS = F Bldg. 01	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA			K0918	Generator fuel was collected by Pioneer Critical Power on 6/2/26 for testing and has been scheduled annually thereafter. Education provided to Maintenance staff on annual generator fuel testing requirements. Administrator will review for completion and Director of Maintenance or designee will ensure completed annually. Results of review will be reported to QAPI committee for review and further recommendations.		07/03/2026

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K0918 SS = F Bldg. 01	Continued from page 3 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.3.8. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/26/2026 between 11:30 AM and 01:30 PM, it was revealed by a review of available documentation that at the time of the survey, the facility could not provide documentation showing the fuel in the generator had been tested to ASTM standards within the last year. An interview with the Administrator and Maintenance verified this deficient finding at the time of discovery.			K0918			07/03/2026
K0921 SS = F Bldg. 01	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a			K0921	Patient care-related electrical appliances and equipment all tested following the Electrical Safety Inspection NFPA 99 2012 edition guidelines. Education provided to Maintenance staff on PCREE requirements. Administrator will review for completion and Director of Maintenance or designee will ensure ongoing compliance. This will be reported to QAPI committee for review and further recommendations.		07/03/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245634		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - AURORA ON ... B. WING		(X3) DATE SURVEY COMPLETED 05/26/2026	
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K0921 SS = F Bldg. 01	Continued from page 4 complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect patient care related electrical appliances and equipment (PCREE) per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.2, 10.3, and 10.5.2.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/26/2026 between 11:30 AM and 01:30 PM, it was revealed by a review of available documentation that at the time of the survey, the facility could not provide documentation showing that the patient care-related electrical appliances and equipment (PCREE) in the facility had been inspected or tested. An interview with the Administrator and Maintenance verified this deficient finding at the time of discovery.			K0921			07/03/2026
K0226 SS = E Bldg. 01	Horizontal Exits CFR(s): NFPA 101 Horizontal Exits Horizontal exits, if used, are in accordance with 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4. 18.2.2.5, 19.2.2.5 This STANDARD is NOT MET as evidenced by:			K0226	Fire caulking was placed around fire alarm wiring. All fire barriers were checked and remain fire-stopped. Director of Maintenance or designee will audit fire barriers semi-annually to ensure they remain fire-stopped. Results of audit will be reported to QAPI committee for review and further recommendations.		07/03/2026

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K0226 SS = E Bldg. 01	Continued from page 5 Based on observation and staff interview, the facility failed to maintain fire barriers per NFPA 101 (2012 edition), Life Safety Code, sections 18.2.2.5, 7.2.4.3.1, and 8.3.1.2. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 05/26/2026 at 01:09 PM, it was revealed by observation that the firewall penetration around the fire alarm wiring above the fire doors near resident room 2302 was not properly fire-stopped. An interview with the Administrator and Maintenance verified this deficient finding at the time of discovery.			K0226			07/03/2026
K0372 SS = E Bldg. 01	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 NEW Smoke barriers shall be constructed to provide at least a one hour fire resistance rating and constructed in accordance with 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations of fully ducted HVAC systems. 18.3.7.3, 18.3.7.4, 18.3.7.5, 8.3 Describe any mechanical smoke control system in REMARKS. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barriers per NFPA 101 (2012 edition), Life Safety Code, sections 18.3.7.1, 18.3.7.3, 8.5.2.2, and 8.5.6.2. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 05/26/2026 at 01:00 PM, it was revealed by observation that the smoke barrier was not fully sealed along the drywall seams above the smoke barrier doors near resident room 2113.			K0372	Fire caulking was placed in drywall seams above the smoke barrier doors. All smoke barriers were checked and remain sealed. Director of Maintenance or designee will audit smoke barriers semi-annually to ensure they remain sealed. Results of audit will be reported to QAPI committee for review and further recommendations.		07/03/2026

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K0372 SS = E Bldg. 01	Continued from page 6 An interview with the Administrator and Maintenance verified this deficient finding at the time of discovery.			K0372			07/03/2026



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
July 28, 2026

Administrator
AURORA ON FRANCE
6500 FRANCE AVENUE
EDINA, MN 55435

RE: CCN: 245634
Cycle Start Date: May 28, 2026

Dear Administrator:

On July 23, 2026, the Minnesota Departments of Health and Public Safety 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.

A handwritten signature in black ink, appearing to read 'M. Poepping', with a stylized flourish at the end.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 28, 2026

Administrator
AURORA ON FRANCE
6500 FRANCE AVENUE
EDINA, MN 55435

Re: Reinspection Results
Event ID: 232C52-H2

Dear Administrator:

On July 23, 2026 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on May 28, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping', with a stylized, cursive script.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us