Electronically Delivered

June 2, 2025

Licensee
Aurora Assisted Living LLC
115 Magnolia Avenue West
Saint Paul, MN 55117

RE: Project Number(s) SL37787016

Dear Licensee:

On April 29, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on February 6, 2025. This follow-up survey verified that the facility is in substantial compliance.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter with your organization's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Renee L. Anderson

Renee Anderson, Supervisor
State Evaluation Team
Email: Renee.L.Anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

JMD

Electronically Delivered

March 7, 2025

Licensee
Aurora Assisted Living LLC
115 Magnolia Avenue West
Saint Paul, MN 55117

RE: Project Number(s) SL37787016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 6, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00
St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $6,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in

a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

Renee L. Anderson

Renee L. Anderson, Supervisor
State Evaluation Team
Email: Renee.L.Anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37787	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA ASSISTED LIVING LLC	115 MAGNOLIA AVENUE WEST SAINT PAUL, MN 55117

(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) COMPLETE DATE
0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL37787016 On February 3, 2025, through February 6, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were three residents; three receiving services under the Assisted Living Facility license. Immediate correction orders were issued February 4, 2025, for SL37787016-0 correction tags 1290 and 2310. The licensee submitted an acceptable plan of correction for each; the scope and severity remain the same.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is 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. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 340 SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever	0 340		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37787	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA ASSISTED LIVING LLC	115 MAGNOLIA AVENUE WEST SAINT PAUL, MN 55117

(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) COMPLETE DATE
0 340	Continued From page 1 the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must: (1) document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to record actions taken to comply with all correction orders from a survey completed September 27, 2022. The lack of action to ensure compliance with regulations had the potential to affect all residents staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive	0 340		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37787	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA ASSISTED LIVING LLC	115 MAGNOLIA AVENUE WEST SAINT PAUL, MN 55117

(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) COMPLETE DATE
0 340	Continued From page 2 or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The result of the licensee's previous survey, concluded on September 27, 2022, was sent to the licensee via email on October 31, 2022. The result communication indicated the licensee was granted an assisted living license. The longest time period for correction (the time frame in which the licensee must document and correct orders) was 21 days from the date the licensee received their results, or October 18, 2022. The licensee's plans of correction (POC) from survey dated September 27, 2022, lacked a documented plan of correction for the following orders: -0580, 144G.42 Subd. 2. Quality management; -0680, 144G.42 Subd. 10. Disaster planning and emergency preparedness plan; -1370, 144G.61 Subd. 2. (a) Training and evaluation of unlicensed personnel; -1380, 144G.61 Subd. 2. (b) Training and evaluation of unlicensed personnel; -1460, 144G.63 Subdivision 1. Orientation of staff and supervisors; -1480, 144G.63 Subd. 3. Orientation to resident; -1490, 144G.63 Subd. 4. Training required relating to dementia, mental illness, and de-escalation; and -1500, 144G.63 Subd. 5. Required annual training. On February 4, 2025, at 8:23 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she had not completed any plans of correction from the survey completed	0 340		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37787	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA ASSISTED LIVING LLC	115 MAGNOLIA AVENUE WEST SAINT PAUL, MN 55117

(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) COMPLETE DATE
0 340	Continued From page 3 September 27, 2022. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before	0 480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37787	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA ASSISTED LIVING LLC	115 MAGNOLIA AVENUE WEST SAINT PAUL, MN 55117

(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) COMPLETE DATE
0 480	Continued From page 4 storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37787	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA ASSISTED LIVING LLC	115 MAGNOLIA AVENUE WEST SAINT PAUL, MN 55117

(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) COMPLETE DATE
0 480	Continued From page 5 The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated February 4, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement and maintain a quality management program appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a	0 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37787	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA ASSISTED LIVING LLC	115 MAGNOLIA AVENUE WEST SAINT PAUL, MN 55117

(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) COMPLETE DATE
0 580	Continued From page 6 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On February 3, 2025, at 10:15 a.m., during the entrance conference, the surveyor requested to review the licensee's quality management plan. Licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she had not created a quality management program or completed a quality management meeting for the program yet. LALD/CNS-A verbalized she planned to get a quality management program and meeting started soon. The licensee's Quality Management Plan policy revised June 25, 2022, indicated, "1. The Assisted Living Director will establish a quality management program to develop and maintain the agency's continuous performance improvement efforts. 2. The Assisted Living Director will establish a Quality Council made up of key staff to develop and implement the agency's quality management program. 3. The Quality Council meetings will be held at least quarterly to evaluate the quality of care. 4. Data and information evaluated by the Quality Council will include at a minimum: a. Complaints and feedback from residents, residents' representatives, residents' families and agency staff; b. Other relevant information. c. Resident services d. Staffing - to determine if staffing changes are	0 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37787	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA ASSISTED LIVING LLC	115 MAGNOLIA AVENUE WEST SAINT PAUL, MN 55117

(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) COMPLETE DATE
0 580	Continued From page 7 needed to ensure safe and competent resident services e. Vulnerable Adult reports to the Common Entry Point; f. Incident reports; g. Medication errors; h. Results of audits of resident records; i. Results of audits of personnel files; j. Results of MDH regular surveys and OHFC surveys of our agency." In addition, included, "5. Minutes of the Quality Council meetings will be summarized for all staff to review and these summaries will be available via email. 6. Quality Council meeting minutes will be retained for two-years and will be made available to the commissioner at the time of survey, investigation, or renewal." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse.	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37787	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA ASSISTED LIVING LLC	115 MAGNOLIA AVENUE WEST SAINT PAUL, MN 55117

(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) COMPLETE DATE
0 630	Continued From page 8 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's was admitted on March 1, 2024, and had diagnoses including chronic obstructive pulmonary disease (COPD-a lung disease), and aneurysm of descending thoracic aorta (an enlargement in the wall behind the heart). R2's service plan dated February 4, 2025, indicated R2 received services including assistance with housekeeping, laundry, meals, bathing, dressing, grooming, toileting, and medication administration. R2's medical record included an IAPP dated January 14, 2025. The IAPP lacked the following required content: - the person's risk of abusing other vulnerable adults. On February 4, 2025, at 11:40 a.m., licensed assisted living director/clinical nurse supervisor	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37787	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA ASSISTED LIVING LLC	115 MAGNOLIA AVENUE WEST SAINT PAUL, MN 55117

(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) COMPLETE DATE
0 630	Continued From page 9 (LALD/CNS)-A stated she may have missed the question in the electronic medical record to assess R2's risk of abuse to other vulnerable adults. LALD/CNS-A stated she would be sure all required content was assessed for each of the licensee's residents. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37787	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA ASSISTED LIVING LLC	115 MAGNOLIA AVENUE WEST SAINT PAUL, MN 55117

(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) COMPLETE DATE
0 660	Continued From page 10 includes a TB facility risk assessment. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On February 3, 2025, at 12:29 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she had not completed a TB facility risk assessment for the licensee. The Minnesota Department of Health (MDH) Assisted Living Resources and Frequently Asked Questions website updated December 13, 2024 included under Tuberculosis Screening "Each facility must establish and maintain a comprehensive TB infection control program according to the most current tuberculosis infection control guidelines issued by the United States CDC, Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers." Also, indicated "Each provider licensed by MDH is required to complete a TB risk assessment annually. Completion of this assessment will assist providers in the development of an infection control committee and in determining the frequency of screening."	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37787	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA ASSISTED LIVING LLC	115 MAGNOLIA AVENUE WEST SAINT PAUL, MN 55117

(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) COMPLETE DATE
0 660	Continued From page 11 The licensee's TB Prevention and Control policy revised June 24, 2022, indicated, "The Clinical Nurse Supervisor is responsible for establishing and maintaining the TB prevention and control program. Responsibilities include: a. Establishment of an infection control team [RN] b. Completion of a written TB risk assessment for the agency using the form provided by the Minnesota Department of Health. c. Annual review and revision as needed of the TB risk assessment for the facility. Based on the risk assessment, the Clinical Nurse Supervisor or RN will determine the frequency of TB screening and testing necessary for assisted living staff." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37787	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA ASSISTED LIVING LLC	115 MAGNOLIA AVENUE WEST SAINT PAUL, MN 55117

(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) COMPLETE DATE
0 680	Continued From page 12 disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document annual review and updates to the emergency preparedness (EP) plan and hazard vulnerability assessment (HVA). This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On February 3, 2025, at 12:24 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she was responsible for the emergency preparedness plans for the licensee. LALD/CNS-A stated she had not had the opportunity to create a facility specific emergency plan with the required content. The licensee's Emergency and Disaster Preparedness policy dated March 25, 2022,	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37787	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA ASSISTED LIVING LLC	115 MAGNOLIA AVENUE WEST SAINT PAUL, MN 55117

(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) COMPLETE DATE
0 680	Continued From page 13 lacked the following required content: -a risk assessment to include hazards like care related emergencies, equipment/utility failures, interruptions in communications/cyber-attacks, loss of all or portion of a facility, interruption to normal supply of essential resources and medical supplies; -development of a communication plan; -a system to track the location of on-duty staff and sheltered residents; -a process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response; -to address role of facility under a waiver declared by the Secretary in accordance with section 1135 of the Act; -development of arrangements with other facilities/providers to receive residents in the event of limitations/cessation of operations to maintain the continuity of services to residents; -a quarterly review of the missing resident policy; and -documentation of two emergency preparedness exercises (an annual full-scale exercise or individual facility-based functional exercise and a second full-scale exercise that was either community-based, an individual facility based functional exercise, a mock disaster drill, or a table-top exercise). On February 3, 2025, at 12:27 p.m., LALD/CNS-A stated the emergency preparedness plan lacked the above information and would ensure the information was developed in the emergency preparedness plan for licensee residents. The licensee's Emergency and Disaster Preparedness policy, dated March 25, 2022, indicated "This facility will be prepared to manage emergency and disaster situations, including	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37787	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA ASSISTED LIVING LLC	115 MAGNOLIA AVENUE WEST SAINT PAUL, MN 55117

(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) COMPLETE DATE
0 680	Continued From page 14 missing residents through our hazard assessment and emergency planning. In addition, included, "3. Based on the HVA, an Emergency Preparedness Plan has been developed. 4. The Emergency Preparedness Plan addresses the following requirements: (a) It is based on and includes a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (b) Includes strategies for addressing emergency events identified by the risk assessment. (c) Addresses our resident population, including, but not limited to, persons at-risk; the type of services the facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. (d) Includes a process for cooperation and collaboration with local, tribal, regional, State, or Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. (e) The emergency disaster plan contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency. 5. A written Communication Plan is complete that addresses the elements listed in 42 C.F.R." The licensee's undated Missing Resident policy indicated, "11. The assisted living director and clinical nurse supervisor will review the missing resident plan at least quarterly and document any changes to the plan." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37787	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA ASSISTED LIVING LLC	115 MAGNOLIA AVENUE WEST SAINT PAUL, MN 55117

(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) COMPLETE DATE
0 680	Continued From page 15 (21) days	0 680		
0 775 SS=E	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide a facility with clear access to egress windows in compliance with Minnesota State Fire Code under Minnesota Rules Chapter 7511. This had the potential to affect residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On February 5, 2025, from 1:57 p.m. to 2:55 p.m.., the surveyor toured the facility with the licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. Resident sleeping room 1 had furniture including a storage shelf with multiple large potted plants located in front of egress window in the room. These items impede access to egress window.	0 775		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37787	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA ASSISTED LIVING LLC	115 MAGNOLIA AVENUE WEST SAINT PAUL, MN 55117

(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) COMPLETE DATE
0 775	Continued From page 16 LALD/CNS-A indicated that residents utilize windows for the sunlight to grow plants but indicated that she understood requirements indicate by the surveyor and that the area would be maintained clear of obstruction. Resident sleeping room 2 had storage shelves and items including a wheelchair and cases placed in front of egress window in the room. LALD/CNS-A acknowledged storage of items impede egress access, and that a new storage option would be explored to maintain area clear of obstruction. During the facility tour on February 5, 2025, these deficient conditions were visually verified by LALD/CNS-A accompanying on the tour who stated they understood requirements to comply with Minnesota State Fire Code under Minnesota Rules Chapter 7511 and maintain egress windows free of obstruction. TIME PERIOD FOR CORRECTION: Two (2) days	0 775		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37787	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA ASSISTED LIVING LLC	115 MAGNOLIA AVENUE WEST SAINT PAUL, MN 55117

(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) COMPLETE DATE
0 810	Continued From page 17 emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37787	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA ASSISTED LIVING LLC	115 MAGNOLIA AVENUE WEST SAINT PAUL, MN 55117

(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) COMPLETE DATE
0 810	Continued From page 18 The findings include: On February 5, 2025, at approximately 2:30 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A provided documentation on the fire safety and evacuation plan (FSEP). The licensee's FSEP failed to include the following: The FSEP did not include fire procedures for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. LALD/CNS-A stated that they had not yet developed or included this document but would take action to create such a plan and include it in the FSEP. The FSEP did not include identification of unique resident needs for evacuation. There was no section in the policy that addressed procedures for resident movement including unique needs for movement or evacuation. LALD/CNS-A stated that they had not yet developed or included this document but would take action to create such a plan and include it in the FSEP. The FSEP did not include employee training records on the FSEP. There was no section in the FSEP that documented staff training. LALD/CNS-A stated that they had not yet developed a staff training program but would take action to create such a plan and include it in the FSEP. Employees must receive training on the FSEP upon hire and at least twice a year thereafter. The FSEP did not include any documentation of	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37787	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA ASSISTED LIVING LLC	115 MAGNOLIA AVENUE WEST SAINT PAUL, MN 55117

(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) COMPLETE DATE
0 810	Continued From page 19 training provided to residents on fire safety or evacuation procedures. Training's must be offered to residents capable of assisting in their own evacuation at least once annually. The FSEP did not include any documentation of fire drills conducted at the facility. LALD/CNS-A stated that they had not implemented fire drills at the facility but would take action to initiate and record fire drills. The surveyor provided information about requirements of fire drills. Evacuation drills are required for employees at least twice a year per shift, and at least once every other month. During interview on February 5, 2025, at 2:30 p.m., the surveyor explained the requirements for frequency of drills, resident training, employee training, and documentation. LALD/CNS-A stated they understood the requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01290 SS=G	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37787	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA ASSISTED LIVING LLC	115 MAGNOLIA AVENUE WEST SAINT PAUL, MN 55117

(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) COMPLETE DATE
01290	Continued From page 20 this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to obtain a cleared Minnesota Department of Human Services (DHS) background study clearance prior to providing services for one of two employees (unlicensed personnel (ULP)-B). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-B was hired on December 18, 2024, and provided direct care and services to the licensee's residents. On February 3, 2025, at 11:35 a.m., the surveyor observed ULP-B assist R2 with medication administration. ULP-B's employee record lacked evidence of a cleared DHS Net Study 2.0 background study, affiliated to the licensee's health facility identification number (HFID) prior to working with residents.	01290	The licensee submitted an acceptable plan of correction; the scope and severity remain at level 3, isolated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37787	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA ASSISTED LIVING LLC	115 MAGNOLIA AVENUE WEST SAINT PAUL, MN 55117

(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) COMPLETE DATE
01290	Continued From page 21 On February 4, 2025, at 8:30 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she forgot to initiate a background study for ULP-B when she was hired. LALD/CNS-A verbalized she completed ULP-B's Net Study background study after the start of the survey. On February 4, 2025, at 8:33 a.m., the surveyor observed the licensee's DHS Net Study 2.0 roster with LALD/CNS-A. The roster indicated ULP-B's background study was initiated February 3, 2025, on the first day of survey. The licensee's Background Checks policy revised June 24, 2022, indicated, "All employees; as well as contractors, and regularly scheduled volunteers of the facility with direct resident contact will undergo a background study through OHS. Only those with satisfactory results will continue to work with the facility and its residents." In addition, the policy included, "1. Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. All employees must pass a background study and all contractors or volunteers with direct resident contact are required to have a background study. "Direct contact" means providing face-to-face care, training, supervision, counseling, consultation, or medication assistance to persons served by the program." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37787	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA ASSISTED LIVING LLC	115 MAGNOLIA AVENUE WEST SAINT PAUL, MN 55117

(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) COMPLETE DATE
01310	Continued From page 22	01310		
01310 SS=F	144G.60 Subd. 3 Licensed health professionals and nurses (a) Licensed health professionals and nurses providing services as staff members of a licensed facility must possess a current Minnesota license or registration to practice. (b) Licensed health professionals and registered nurses must be competent in assessing resident needs, planning appropriate services to meet resident needs, implementing services, and supervising staff if assigned. (c) Nothing in this section limits or expands the rights of nurses or licensed health professionals to provide services within the scope of their licenses or registrations, as provided by law. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN), who was providing services as an employee of the licensed facility, had a current Minnesota license or registration to practice, for one of one employee (licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A). This had the potential to affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	01310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37787	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA ASSISTED LIVING LLC	115 MAGNOLIA AVENUE WEST SAINT PAUL, MN 55117

(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) COMPLETE DATE
01310	Continued From page 23 The findings include: LALD/CNS-A was hired on March 20, 2022, and provided direct nursing cares of the licensee's residents and clinical supervision of the unlicensed personnel. On February 3, 2025, at 7:36 a.m., the surveyor observed the Minnesota (MN) Board of Nursing online licensure verification system which indicated LALD/CNS-A's RN license expired on December 31, 2024. During the entrance conference on February 3, 2025, at 10:15 a.m., LALD/CNS-A stated she was the only registered nurse employed with the licensee and she provided all the nursing cares and on call nursing services for the licensee's residents. R2's medical record included a nursing assessment dated January 14, 2025, completed by LALD/CNS-A, during the time LALD/CNS-A's RN license was expired. On February 3, 2025, at 10:52 a.m., LALD/CNS-A stated she was not aware her RN license had expired. LALD/CNS-A verbalized she recently updated her LALD license and must have overlooked updating her RN license. At the time of survey, LALD/CNS-A completed her RN license renewal on the MN Board of Nursing website. Minnesota State Statute 148.283 UNAUTHORIZED PRACTICE OF PROFESSIONAL, ADVANCED PRACTICE REGISTERED, AND PRACTICAL NURSING indicated, "The practice of advanced practice, professional, or practical nursing by any person	01310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37787	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA ASSISTED LIVING LLC	115 MAGNOLIA AVENUE WEST SAINT PAUL, MN 55117

(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) COMPLETE DATE
01310	Continued From page 24 who has not been licensed to practice advanced practice, professional, or practical nursing under the provisions of sections 148.171 to 148.285, or whose license has been suspended or revoked, or whose registration or national credential has expired, is hereby declared to be inimical to the public health and welfare and to constitute a public nuisance. Upon a complaint being made by the board or any prosecuting officer, and upon a proper showing of the facts, the district court of the county where such practice occurred may enjoin such acts and practice. Such injunction proceeding shall be in addition to, and not in lieu of, all other penalties and remedies provided by law." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01310		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident.	01440		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37787	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA ASSISTED LIVING LLC	115 MAGNOLIA AVENUE WEST SAINT PAUL, MN 55117

(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) COMPLETE DATE
01440	Continued From page 25 (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted direct supervision of staff performing delegated nursing or therapy tasks within 30 days of first providing those services for one of one employee (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-B was hired on December 18, 2024, to provide direct care services to residents of the assisted living facility. On February 3, 2025, at 11:35 a.m., the surveyor observed ULP-B assist R2 with medication administration. ULP-B's employee record lacked documentation	01440		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37787	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA ASSISTED LIVING LLC	115 MAGNOLIA AVENUE WEST SAINT PAUL, MN 55117

(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) COMPLETE DATE
01440	Continued From page 26 of a 30-day supervision of a delegated nursing task to include observation of the staff administering the medication or treatment and the interaction with the resident. On February 13, 2025, at 12:40 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she was responsible to make sure all caregiver training was completed. LALD/CNS-A stated she had not completed a 30-day supervision of a delegated nursing task for ULP-B. LALD/CNS-A verbalized she planned to implement a process to get the 30-day supervisions completed with all employees. The licensee's Delegation of Nursing Tasks policy, revised June 24, 2024, indicated "Unlicensed personnel (ULP) may perform nursing care services beyond their usual and customary roles if delegated by the RN and will perform these tasks under the supervision of a RN." In addition, included, "PROCEDURE: 1. The RN will complete an assessment of the resident and determine need for nursing services. 2. The RN will develop a service plan for providing the services according to the resident's needs and preferences. 3. Verify the ULP is trained and competent and is instructed in the proper methods to perform the task with respect to the specific resident; if the ULP is not trained, the RN will provide training in-person, verbally, or through other acceptable methods. 4. The RN or other appropriately licensed staff will document any ULP training and/or competencies. 5. When needed, the RN will provide written instructions for performing the procedure to the ULP. 6. The RN will provide supervision appropriate for	01440		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37787	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA ASSISTED LIVING LLC	115 MAGNOLIA AVENUE WEST SAINT PAUL, MN 55117

(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) COMPLETE DATE
01440	Continued From page 27 the task." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37787	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA ASSISTED LIVING LLC	115 MAGNOLIA AVENUE WEST SAINT PAUL, MN 55117

(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) COMPLETE DATE
01620	Continued From page 28 (RN) conducted ongoing resident monitoring and reassessment, utilizing a uniform assessment tool, no more than 14 days after start of services, and not more than 90 days from the previous assessment for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On February 3, 2025, at 10:15 a.m., during the entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee completed nursing assessments upon admission, within 14 days of admission, every 90 days, and with a change in condition. R2 was admitted on March 1, 2024, and received services including housekeeping, laundry, meals, dressing, grooming, toileting, safety checks, and medication administration. R2's medical record included an initial comprehensive RN assessment, dated March 7, 2024, and a subsequent nursing assessment dated April 17, 2024, greater than 14-days after start of services. R2's medical record included a comprehensive RN assessment, dated September 19, 2024, and a subsequent assessment dated January 14,	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37787	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA ASSISTED LIVING LLC	115 MAGNOLIA AVENUE WEST SAINT PAUL, MN 55117

(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) COMPLETE DATE
01620	Continued From page 29 2025, greater than 90 days after. On February 4, 2025, at 11:30 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she was aware R2's 14-day and 90-day assessments were completed late. The licensee's Initial and On-Going Nursing Assessment of Residents policy, revised June 28, 2023, indicated, 1. A RN will complete the following comprehensive nursing assessments of the resident's physical, mental, and cognitive needs as required: a. Pre-Admission Assessment b. 14-day assessment: completed up to 14-days after start of services c. Ongoing assessment: completed periodically but no less than every 90-days d. Change in resident condition." No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37787	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA ASSISTED LIVING LLC	115 MAGNOLIA AVENUE WEST SAINT PAUL, MN 55117

(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) COMPLETE DATE
01640	Continued From page 30 and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a service plan had been signed or authenticated by the facility representative and by the resident, or the resident's representative, to document agreement on services to be provided, for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 was admitted on March 1, 2024, and had diagnoses including chronic obstructive pulmonary disease (COPD-a lung disease), and aneurysm of descending thoracic aorta (an enlargement in the wall behind the heart). R2's medical record included a document titled	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37787	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA ASSISTED LIVING LLC	115 MAGNOLIA AVENUE WEST SAINT PAUL, MN 55117

(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) COMPLETE DATE
01640	Continued From page 31 Planned Services, printed February 4, 2025. The plan indicated R2 received services including assistance with housekeeping, laundry, meals, dressing, grooming, toileting, safety checks, and medication administration. R2's medical record lacked a service plan with a signature or other authentication by the facility and by the resident or their representative, documenting agreement on the services to be provided. On February 4, 2025, at 9:45 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she was not aware of all the service plan content and authentication to be completed by the resident or the resident's representative. LALD/CNS-A stated she planned to begin using the Service Plan (Waiver) - Addendum to Contract documents for all the licensee's residents and would ensure they were authenticated, as required. The licensee's Contents of Service Plans policy revised June 28, 2023, indicated, "1. A proposed service plan is established after completion of individualized, initial assessment. 2. A finalized service plan will be completed no later than 14 calendar days after initiation of services. 3. Service plans and any revisions to services plans will have a signature or other authentication by the facility and by the resident. Other authentication could be email confirmation accepting terms of a service agreement or other method deemed appropriate by the assisted living." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37787	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA ASSISTED LIVING LLC	115 MAGNOLIA AVENUE WEST SAINT PAUL, MN 55117

(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) COMPLETE DATE
01640	Continued From page 32 (21) days	01640		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care standards, medical or nursing standards for one of one resident (R3) who utilized hospital style side bed rails and two of two residents (R2, R4) who utilized consumer-style bed rails. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: HOSPITAL-STYLE BED RAILS R3 was admitted on June 29, 2023, and had diagnoses which included end stage renal disease (ESRD) (a kidney disease). On February 4, 2025, at 9:45 a.m., the surveyor	02310	The licensee submitted an acceptable plan of correction; the scope and severity remain at level 3, widespread.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37787	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA ASSISTED LIVING LLC	115 MAGNOLIA AVENUE WEST SAINT PAUL, MN 55117

(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) COMPLETE DATE
02310	Continued From page 33 observed R3's bedroom with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. R3's bedroom included one hospital-style bed with a full side rail on the left side. The bed rail was in the upright position. LALD/CNS-A stated they removed one of the bedrails, so R2 only had the on full length bedrail on the left side now. R3's nursing assessment dated January 14, 2025, indicated under the section labeled "Safety" - " Bed rails in use, include description and condition of bed rail: 2 bedrails used." R3's medical record lacked: -assessment for appropriateness and safe use of bed rails; and -documentation of measurements of Food and Drug Administration (FDA)-identified zones of entrapment. CONSUMER-STYLE PORTABLE BED RAILS R2 R2 was admitted on March 1, 2024, and had diagnoses which included chronic obstructive pulmonary disease (COPD-a lung disease), and hypertension (high blood pressure). On February 4, 2025, at 9:47 a.m., the surveyor observed R2's bedroom with LALD/CNS-A. R2 was observed lying in his bed which included a "U" shaped consumer-style portable bed rail on the left side of R2's bed. R2's medical record included a nursing assessment dated January 14, 2025. The assessment indicated, "Safety - No assistive devices needed for bed," and, "The bed safety zone assessment is not applicable, either resident has no bed rails in use or has portable	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37787	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA ASSISTED LIVING LLC	115 MAGNOLIA AVENUE WEST SAINT PAUL, MN 55117

(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) COMPLETE DATE
02310	Continued From page 34 bed rails that are installed on a consumer bed." Also, R2's record lacked evidence of education including risk and benefits of bed rails was reviewed with the resident or the resident's representative. R4 R4 was admitted on March 23, 2022, and had diagnoses which included ESRD. On February 4, 2025, at 9:43 a.m., the surveyor observed R4's bedroom with LALD/CNS-A. R4's bed included a "U" shaped consumer-style bed rail on the left side of R4's bed. R4's medical record included a nursing assessment dated January 18, 2025. The assessment indicated, "Safety - Bed Safety -Side rail/s are appropriate based upon assessed need, specify: family brought in pt's partial side rail from home." The licensee lacked evidence to show the following requirements for R2 and R4: -the consumer-style portable bed rails were installed and maintained per manufacturer guidelines; -education was provided to the resident and/or their representative on the benefits and risks of bed rails; and -evidence the licensee ensured the consumer-style portable bed rails were not recalled by the Consumer Product Safety Committee (CPSC). On February 4, 2025, at 10:00 a.m., LALD/CNS-A stated the licensee did not have a process to identify when a resident used a hospital-style or consumer-style bed rail. LALD/CNS-A also stated she had not completed bed rail assessments with	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37787	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA ASSISTED LIVING LLC	115 MAGNOLIA AVENUE WEST SAINT PAUL, MN 55117

(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) COMPLETE DATE
02310	Continued From page 35 measurements of entrapment zones for R3. LALD/CNS-A verbalized she was not aware bed rail assessments, including measurements, were required. In addition, LALD/CNS-A stated she did not have the manufacturer directions for R2 and R4's consumer-style bed rails. Finally, LALD-CNS-A verbalized she had not checked the CPSC website for recalls. The licensee's undated Use of Side Rails policy indicated, "Side rails will not be used in the home setting except in situations where assessment determines they are necessary for safety of the client. If the client or client· s representative wants side rails on the bed, agency RN will educate the client/representative about the risks related to side rails, and will assess whether the side rails meet FDA standards. If the side rails do not meet safety guidelines, staff will recommend alternative options to reduce the fall risk. Physician orders will be obtained for the side rails if indicated." In addition included, "1. When notified that a client has a side rail or that the client or their representative is requesting side rails, the RN will assess and evaluate what the client's needs are and if the client can safely utilize the side rail/equipment. Assessment will determine whether the equipment meets the FDA standards for side rails." The Food and Drug Administration (FDA)'s, A Guide to Bed Safety, dated March 10, 2006, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients." The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37787	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA ASSISTED LIVING LLC	115 MAGNOLIA AVENUE WEST SAINT PAUL, MN 55117

(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) COMPLETE DATE
02310	Continued From page 36 bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQs), last updated December 12, 2024, indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment: - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements." In addition, included, ""If a licensee is unable to	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37787	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA ASSISTED LIVING LLC	115 MAGNOLIA AVENUE WEST SAINT PAUL, MN 55117

(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) COMPLETE DATE
02310	Continued From page 37 locate manufacturer's guidelines, they are unable to assess and determine if the portable bed rail is being used appropriately and installed properly." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	02310		

Minnesota Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975
651-201-4500

Type: Follow-Up
Date: *02/25/25*
Time: 10:37:08
Report: 1021251043

Food and Beverage Establishment Inspection Report

Location:
Aurora Assisted Living LLC
115 MAgnolia Avenue W
St Paul, MN
Ramsey County, 62

Establishment Info:
ID #: 0040809
Risk:
Announced Inspection: Yes

License Categories:

Expires on: 08/31/23

Operator:

Phone #: 6128595064
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

No NEW orders were issued during this inspection.

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: TOFU - FRIGIDAIRE REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: BOK CHOY - FRIGIDAIRE REFRIGERATOR
Violation Issued: No

Process/Item: Ambient Temperature
Temperature: 37 Degrees Fahrenheit - Location: FRIGIDAIRE REFRIGERATOR
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	0	0

TODAY'S FOLLOW UP WAS TO ADDRESS AND CLEAR PREVIOUSLY WRITTEN ORDERS FROM A FULL INSPECTION CONDUCTED ON 02/04/25. 4 OUT OF 4 ORDERS WERE CLEARED FROM THE REPORT.

Type: Follow-Up
Date: *02/25/25*
Time: 10:37:08
Report: 1021251043
Aurora Assisted Living LLC

Food and Beverage Establishment Inspection Report

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1021251043 of 02/25/25.

Certified Food Protection Manager: PANG VANG

Certification Number: FM108389 Expires: 11/10/27

Inspection report reviewed with person in charge and emailed.

Signed: _____
PANG VANG
LALD/CFPM

Signed: _____
Melissa Ramos
Environmental Health Specialist
Metro District Office
651-201-4495
Melissa.Ramos@state.mn.us

Minnesota Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *02/04/25*
Time: 10:45:39
Report: 1021251021

Food and Beverage Establishment Inspection Report

Location:

Aurora Assisted Living LLC
115 MAgnolia Avenue W
St Paul, MN
Ramsey County, 62

Establishment Info:

ID #: 0040809
Risk:
Announced Inspection: Yes

License Categories:

Expires on: 08/31/23

Operator:

Phone #: 6128595064
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

2-200 Employee Health

2-201.11C ***** Priority 1 *****

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority.

NO EMPLOYEE ILLNESS LOG ON-SITE. DISCUSSED EMPLOYEE ILLNESS POLICY AND RECORDING WITH LALD. AN MDH EMPLOYEE ILLNESS SENT WITH REPORT.

Comply By: 02/06/25

3-500B Microbial Control: hot and cold holding

3-501.16A2 ***** Priority 1 *****

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

RAW SAUSAGE (46F), PORRIDGE (44F), AND COOKED PORK (44F) FOUND IN THE KITCHEN REFRIGERATOR MEASURED ABOVE 41F. LALD ADJUSTED THE TEMPERATURE OF THE KITCHEN REFRIGERATOR AND WILL MONITOR TCS FOODS.

Comply By: 02/04/25

4-300 Equipment Numbers and Capacities

4-302.13B ***** Priority 2 *****

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

ESTABLISHMENT DOES NOT HAVE A MEASURING DEVICE THAT INDICATES THE FINAL UTENSIL SURFACE TEMPERATURE IN DISH MACHINE. PROVIDE. ONE THERMOLABEL WAS LEFT ON-SITE.

Comply By: 02/12/25

4-300 Equipment Numbers and Capacities

4-302.14 ***** Priority 2 *****

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

TEST KIT ON-SITE TO MEASURE THE CONCENTRATION OF QUATERNARY AMMONIUM (QUAT) EXPIRED LAST YEAR. PROVIDE NEW TEST KIT.

Comply By: 02/12/25

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200PPM at Degrees Fahrenheit
Location: SANI BUCKET
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 46 Degrees Fahrenheit - Location: COOKED PORK - KITCHEN REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding
Temperature: 44 Degrees Fahrenheit - Location: RAW SAUSAGE - KITCHEN REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding
Temperature: 44 Degrees Fahrenheit - Location: PORRIDGE - KITCHEN REFRIGERATOR
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	2	2	0

All FINDINGS ON THIS REPORT WERE DISCUSSED WITH LALD, PANG VANG AND HEALTH REGULATION DIVISION NURSE EVALUATOR, DEDE HINNENDAEL.

THIS FACILITY IS A RESIDENTIAL HOME AND THEY CURRENTLY HAVE 3 CLIENTS AND THE FACILITY CAN HAVE UP TO 5 CLIENTS.

OBSERVED PORRIDGE, RICE, COOKED PORK, AND OTHER COOKED TCS FOOD ITEMS IN THE KITCHEN REFRIGERATOR THAT WERE FROM THE PREVIOUS DAY. DISCUSSED WITH LALD THAT ALL COOKED TCS FOODS MUST BE USED FOR SAME-DAY SERVICE ONLY.

THE KITCHEN HAS RESIDENTIAL EQUIPMENT, LAMINATE COUNTERTOPS AND TEXTURED CEILING. PHYSICAL FACILITY ITEMS WILL BE MONITORED DURING FUTURE INSPECTIONS.

Type: Full
Date: *02/04/25*
Time: 10:45:39
Report: 1021251021
Aurora Assisted Living LLC

Food and Beverage Establishment Inspection Report

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1021251021 of 02/04/25.

Certified Food Protection Manager: PANG VANG

Certification Number: FM108389 Expires: 11/10/27

Inspection report reviewed with person in charge and emailed.

Signed: _____
PANG VANG
LALD/CFPM

Signed: _____
Melissa Ramos
Environmental Health Specialist
Metro District Office
651-201-4495
Melissa.Ramos@state.mn.us