Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 11, 2024

Administrator
Aurora On France
6500 France Avenue
Edina, MN 55435

RE: CCN: 245634
Cycle Start Date: September 24, 2024

Dear Administrator:

On September 24, 2024, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

LeAnn Huseth, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by December 24, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by March 24, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the

Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

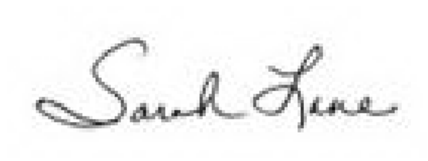
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245634	A. BUILDING _____ B. WING _____	C 09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA ON FRANCE	6500 FRANCE AVENUE EDINA, MN 55435

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 9/23/24 to 9/24/24, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed. H56346230C (MN00105180) H56348420C (MN00105889) H56346230C (MN00105165) H56348425C (MN00106112) H56348424C (MN00106110) H56348422C (MN00099585) H56348501C (MN00105883) with deficiencies issued at F609, F610. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or	F 609		11/5/24

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

Electronically Signed | 10/21/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245634	A. BUILDING _____ B. WING _____	C 09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA ON FRANCE	6500 FRANCE AVENUE EDINA, MN 55435

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 1 mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to report immediately, no later than 2 hours, to the State Agency (SA), in accordance with established policies and procedures, an allegation of staff to resident abuse for 1 of 3 residents (R5) who were reviewed for allegations of abuse. Findings include: R5's admission Minimum Data Set (MDS) assessment dated 8/12/24, identified R5's cognitive status was unable to be determined and had diagnoses which included stroke, hypertension (elevated blood pressure), and	F 609	1. Corrective Acton: Investigation completed including interviews with R5 and staff with no evidence that inappropriate hand gesture occurred. Identified patient□s difficulty with communicating due to Aphasia diagnosis. Patient has been given an iPad to assist with communication. Care plan has been updated and staff have been educated. 2. Corrective Action as it applies to other residents: Reviewed grievance log, no other allegations of abuse or neglect reported. Interviews conducted with other residents to ensure there are no concerns with quality of care.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245634	A. BUILDING _____ B. WING _____	C 09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA ON FRANCE	6500 FRANCE AVENUE EDINA, MN 55435

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 2 aphasia (a language disorder that affects a person's ability to understand and communicate language.) Identified R5 required extensive assistance with activities of daily living (ADL's) which included bed mobility, transfers, and toileting. R5's care plan revised 9/16/24, identified R5 was at risk for vulnerability related to recent placement and R5 would remain free from any physical, mental and emotional harm. Care plan directed staff to cue and intervene as needed for safety. During an interview on 9/23/24 at 11:52 a.m., family member (FM)-A stated on 8/8/24, R5 called her and was very upset and crying. However, due to R5's aphasia, FM-A stated she was not able to understand R5 over the phone so she went to the facility the next morning to discuss with R5 in person. FM-A stated on 8/9/24, R5 informed her that a staff member made a gesture by putting their middle finger up and directed it at R5 during cares. FM-A stated R5 was visibly upset as they talked about it. During the interview, R5 put her middle finger up as an example of what had happened to her. FM-A stated both she and R5 felt that what the staff member did was an abusive gesture toward R5. FM-A stated she had notified the social worker (SW) on 8/9/24, regarding the allegation of abuse toward R5. Review of facility reported incidents to the SA lacked documentation of the SA being notified of the allegation of abuse toward R5. During an interview on 9/23/24 at 3:11 p.m., SW stated FM-A had informed her R5 reported a staff member put up their middle finger towards R5.	F 609	3. Date of completion: 11/5/24 4. Reoccurrence will be prevented by: All staff educated on the requirements of reporting of alleged violations. Specifically, this education focused on the facility□s responsibility to ensure alleged violations involving misappropriation, neglect and/or abuse are immediately reported to the Administrator and respective State Agency as indicated. Grievance log is reviewed at QAPI to identify any trends and ensure alleged violations are appropriately reported. Administrator or designee will perform audits of each reported concern to ensure appropriate timeline and reporting requirements are followed. Audits will take place weekly x 4 weeks and monthly x 3 months to ensure ongoing and sustained compliance with this alleged deficient practice. Audit findings will be reported to the QAPI committee to review for trends and concerns. 5. The correction will be monitored by: Administrator or designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245634	A. BUILDING _____ B. WING _____	C 09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA ON FRANCE	6500 FRANCE AVENUE EDINA, MN 55435

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 3 SW stated she attempted to talk with R5 however, because of R5's aphasia, SW was not able to completely understand what R5 was attempting to say. SW reported the allegation of abuse to the director of nursing (DON). SW stated she did not feel the incident was reportable to the SA since SW had not heard the allegation of abuse directly from R5 therefore, the allegation of abuse was only FM-A's interpretation and may not have actually happened. During an interview on 9/24/24 at 8:50 a.m., DON stated he spoke with R5 on 8/9/24, after he was made aware R5 was upset. DON stated after talking with R5, he had assumed R5 was upset with the hospital she had been at prior to being admitted to the facility. DON verified the allegation of abuse had not been reported to the SA since he was not aware of the allegation of abuse. DON stated if he had been informed of the allegation of abuse, he felt that was a reportable event and his expectation would have been that it would have been reported immediately but no more than two hours after forming the suspicion of abuse. During an interview on 9/24/24 at 9:40 a.m., administrator stated on 8/9/24 , FM-A had called her and stated R5 was very upset and someone should check on R5. Administrator stated she had not been told why R5 was upset however, had told DON that R5 was upset and asked DON to go and visit with R5. Administrator stated at that time, DON had felt R5 was in her normal state. Administrator stated since DON had not determined any allegation of abuse had occurred after visiting with R5, she did not feel it was a reportable event. Administrator indicated if DON had determined there had been an allegation of	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245634	A. BUILDING _____ B. WING _____	C 09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA ON FRANCE	6500 FRANCE AVENUE EDINA, MN 55435

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 4 abuse, it would have been a reportable event. Review of a facility policy titled Vulnerable Adult - Abuse Prohibition Plan (Preventing,Screening, Identifying, Preventing, Training, Protecting, Reporting and Response, Investigating, to Maltreatment, Accidents and Unusual Occurrences) revised 10/6/22, identified mandated reporters in skilled nursing facilities ensured that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported, and a report made immediately, but not later than 2 hours after the allegation made was identified. Policy defined verbal abuse as use of oral, written or gestured language which willfully included disparaging and derogatory terms to residents or their families, or within their hearing distance regardless to their age, ability to comprehend or disability. Speaking to the resident in a derogatory manner or using profanity against them.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all	F 610		11/5/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245634	A. BUILDING _____ B. WING _____	C 09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA ON FRANCE	6500 FRANCE AVENUE EDINA, MN 55435

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 5 investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete an investigation and ensure protection for residents following an allegation of a staff to resident abuse for 1 of 3 residents (R5) investigated for abuse. Findings include: R5's admission Minimum Data Set (MDS) assessment dated 8/12/24, identified R5's cognitive status was unable to be determined and had diagnoses which included stroke, hypertension (elevated blood pressure), and aphasia (a language disorder that affects a person's ability to understand and communicate language.) Identified R5 required extensive assistance with activities of daily living (ADL's) which included bed mobility, transfers, and toileting. R5's care plan revised 9/16/24, identified R5 was at risk for vulnerability related to recent placement and R5 would remain free from any physical, mental and emotional harm. Care plan directed staff to cue and intervene as needed for safety. During an interview on 9/23/24 at 11:52 a.m., family member (FM)-A stated on 8/8/24, R5 called her and was very upset and crying. However, due to R5's aphasia, FM-A stated she was not able to understand R5 over the phone so	F 610	1. Corrective Acton: Investigation completed including interviews with R5 and staff with no evidence that inappropriate hand gesture occurred. Identified patient□s difficulty with communicating due to Aphasia diagnosis. Patient has been given an iPad to assist with communication. Care plan has been updated and staff have been educated. 2. Corrective Action as it applies to other residents: Reviewed grievance log to ensure all concerns were properly investigated, no other allegations of abuse or neglect reported. Interviews conducted with other residents to ensure there are no concerns with quality of care. 3. Date of completion: 11/5/24 4. Reoccurrence will be prevented by: Education provided to nurse managers and social services on investigation of reported alleged violations. Grievance log is reviewed at QAPI to identify any trends and ensure alleged violations are appropriately investigated. Administrator or designee will perform audits of each reported concern to ensure appropriate timeline, reporting, and investigation requirements are followed. Audits will take place weekly x 4 weeks and monthly x 3 months to ensure ongoing and sustained compliance with this alleged deficient	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245634	A. BUILDING _____ B. WING _____	C 09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA ON FRANCE	6500 FRANCE AVENUE EDINA, MN 55435

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 6 she went to the facility the next morning to discuss with R5 in person. FM-A stated on 8/9/24, R5 informed her a staff member made a gesture by putting their middle finger up and directed it at R5 during cares. FM-A stated R5 was visibly upset as they talked about it. During the interview, R5 put her middle finger up to show what happened to her. FM-A stated both she and R5 felt that what the staff member did was an abusive gesture toward R5. FM-A stated she had contacted the social worker (SW) on 8/9/24, and reported the allegation of abuse toward R5. Review of facility reported incidents to the SA lacked documentation of an investigation report being submitted to the SA. During an interview on 9/23/24 at 3:11 p.m., SW stated FM-A had informed her R5 reported a staff member had made a gesture towards her with her middle finger. SW stated she attempted to discuss with R5 and because of R5's aphasia, SW was not able to understand what R5 was trying to say. SW reported the allegation of abuse to the director of nursing (DON). SW stated she had not completed any further investigation regarding the allegation of abuse since she was unable to determine if the abuse had actually occurred. During an interview on 9/24/24 at 8:50 a.m., DON stated he was made aware that R5 had been upset and talked with R5 on 8/9/24,,about it. DON stated after talking to R5, he had assumed R5 was upset with the hospital she had been at prior to being admitted to the facility. DON stated he was not aware of the allegation of abuse and as a result an investigation of the allegation had not been completed. DON verified the unidentified	F 610	practice. Audit findings will be reported to the QAPI committee to review for trends and concerns. 5. The correction will be monitored by: Administrator or designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245634	A. BUILDING _____ B. WING _____	C 09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA ON FRANCE	6500 FRANCE AVENUE EDINA, MN 55435

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 7 alleged perpetrator (AP) would have had continued access to R5 and other vulnerable residents as a result of not completing an investigation. DON stated if he had known about the allegation of abuse, an investigation would have been completed and the AP would have been removed from the schedule during the investigation. During an interview on 9/24/24 at 9:40 a.m., administrator verified no investigation had been completed regarding the allegation of abuse of a staff member towards R5. As a result, the unidentified AP would have had continued access to R5 and other vulnerable residents. Administrator stated had the allegation of abuse been verified, the facility would have immediately initiated an investigation and removed any AP's from the schedule pending the investigation. Review of a facility policy titled Vulnerable Adult - Abuse Prohibition Plan (Preventing,Screening, Identifying, Preventing, Training, Protecting, Reporting and Response, Investigating, to Maltreatment, Accidents and Unusual Occurrences) revised 10/6/22, identified during the shift that the alleged abuse/neglect, unexplained injury or suspected crime was first observed, a mandated reporter/covered individual would immediately make an initial report to their supervisor, after securing the resident's safety. Steps would be taken to ensure that no resident in the facility remained in danger of maltreatment, including medical intervention if needed. Further identified immediate steps were taken to protect the vulnerable adult from harm while the situation was being investigated and the original reporter was assured that retaliation was not tolerated. Upon	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245634	A. BUILDING _____ B. WING _____	C 09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA ON FRANCE	6500 FRANCE AVENUE EDINA, MN 55435

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 8 report to a supervisor of the suspected abuse, the employee in question would be interviewed, and suspended pending investigation. This was for the protection of the resident.	F 610		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

October 11, 2024

Administrator
Aurora On France
6500 France Avenue
Edina, MN 55435

Re: Event ID: IT1411

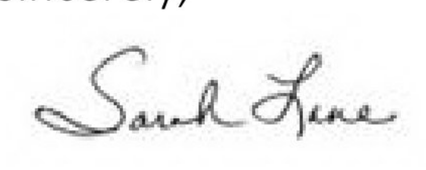
Dear Administrator:

The above facility survey was completed on September 24, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31815	A. BUILDING: _____ B. WING _____	C 09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA ON FRANCE	6500 FRANCE AVENUE EDINA, MN 55435

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 9/23/24 to 9/24/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure. The following complaints were reviewed during	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31815	A. BUILDING: _____ B. WING _____	C 09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA ON FRANCE	6500 FRANCE AVENUE EDINA, MN 55435

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 the survey: H56346230C (MN00105180) H56348420C (MN00105889) H56346230C (MN00105165) H56348425C (MN00106112) H56348424C (MN00106110) H56348422C (MN00099585) H56348501C (MN00105883), with no licensing orders issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		