Electronically Delivered

July 21, 2023

Licensee
Aurora On France Senior Living
6500 France Avenue South
Edina, MN 55435

RE: Project Number(s) SL32728015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 30, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the 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. The 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.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
The MDH may impose a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The MDH also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual

assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program = $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. 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 the MDH within 15 calendar days of the correction order receipt date.

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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 MDH 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. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

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.

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,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 651-281-9796

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32728	A. BUILDING: _____ B. WING _____	06/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA ON FRANCE SENIOR LIVING	6500 FRANCE AVENUE SOUTH 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
0 000	Initial Comments ******ATTENTION****** 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: SL32728015 On June 26, 2023, through June 30, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 110 active residents; 78 receiving services under the Assisted Living with Dementia Care license.	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 License Providers. 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 surveyors' 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 subd. 1, 2, and 3.	
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that	0 510		

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0 510	Continued From page 1 complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control and current recommendations for hand hygiene. This had the potential to affect all the licensee's 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 the residents). The findings include: On June 27, 2023, at 7:00 a.m., during a continuous medication and treatment administration observation, the surveyor made the following observations: - Unlicensed personnel (ULP)-B failed to perform hand hygiene prior to donning (putting	0 510		

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0 510	Continued From page 2 on) gloves and assisting R3 with administration of oral and inhaled medications. - ULP-B left R3's room, doffed (removed) gloves, failed to perform hand hygiene, donned another pair of gloves, and proceeded to assist with medication administration for resident in another room. - ULP-B left the room, doffed gloves, and donned a new pair of gloves, but failed to perform hand hygiene. - ULP-B set up medications and gathered supplies for R2. While in R2's room, ULP-B applied two lidocaine patches (patched applied to reduce pain) to R2's lower back, then applied Baza Protect Moisture Cream to R2's buttocks. ULP-B left the room to doff and don new gloves but failed to perform hand hygiene. Upon returning to the room, ULP-B assisted R2 with inhaled, oral, and eye medications. ULP-B assisted R2 with TED (thrombo-embolic deterrent) stockings, regular stockings, and application of shoes. ULP-B doffed gloves and washed their hands. On June 27, 2023, at 12:30 p.m., clinical nurse supervisor (CNS)-D stated staff received training on hand hygiene and infection control at licensee's corporate education class, during online education modules, and during direct supervision at the facility. CNS-D stated the expectation is for all staff to complete hand hygiene prior to donning and immediately after doffing gloves. The Center of Disease Control (CDC) Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings dated November 29, 2022, recommended hand hygiene to be performed immediately before touching a patient (resident), before performing an aseptic	0 510		

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0 510	Continued From page 3 task (e.g., placing an indwelling device) or handling invasive medical devices, before moving from work on a soiled body site to a clean body site on the same patient (resident), after touching a patient or the patient's (resident's) immediate environment, after contact with blood, body fluids or contaminated surfaces, and immediately after glove removal. The licensee's Standard Infection Control Precautions policy dated August 1, 2022, indicated staff will wash hands: - after touching blood, body fluids, feces, or contaminated items (regardless of whether gloves are worn); - before putting on gloves; - immediately after gloves are removed; and - as necessary, between tasks and procedures on the same resident to prevent cross-contamination of different body sites, and between all resident contacts. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 630 SS=E	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	0 630		

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0 630	Continued From page 4 and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted an accurate assessment of the vulnerabilities of the resident for two of four residents (R4, R5). 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 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: R4 R4 admitted to the memory care secured area on December 29, 2021, with diagnoses of dementia, anxiety, and type 2 diabetes. R4's record included a 90-day Comprehensive and Basic Assessment dated April 24, 2023. R5 R5 admitted to the memory care secured area on December 28, 2022, with diagnosis of Alzheimer's disease, and non-traumatic subarachnoid hemorrhage (bleeding within the brain).	0 630		

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0 630	Continued From page 5 R5's record included a 90-day Comprehensive and Basic Assessment dated May 29, 2023. R4 and R5's basic and comprehensive RN assessment dated April 24, 2023, and May 29, 2023, respectively, lacked an accurate assessment of vulnerabilities. R4 and R5's vulnerabilities and abuse prevention assessment included: - question 8, is the client at risk for being sexually abused by others? No; - question 9, is the client at risk for being physically abused by others? No; and - question 10, is the resident at risk for being verbally abused by others? No. On June 28, 2023, at 11:33 a.m., clinical nurse supervisor (CNS)-D and regional manager (RM)-F agreed that the residents in the memory care secured area should have been assessed as being vulnerable to physical, verbal, or sexual abuse and the answer of "no" to these questions was not accurate. CNS-D indicated this would be reviewed with all of the nurses. The licensee's Assessment of Clients - Initial and Ongoing policy revised August 1, 2021, included "b. The comprehensive assessment will include the client's areas of vulnerability and susceptibility to maltreatment and whether the client poses a risk to other vulnerable adults. The RN will use this assessment as the basis for the client's individual abuse prevention plan that identifies the specific measures to be taken to minimize the risk of maltreatment to the client or to other vulnerable adults. The RN will incorporate the abuse prevention plan and interventions into the client's comprehensive care plan." Additionally included "Based on the RN's assessment of the client's needs and vulnerabilities. the RN will	0 630		

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0 630	Continued From page 6 develop a service plan that addresses the client's needs and includes interventions necessary to reduce the client's risk of maltreatment or to reduce the risk that the client may pose to other vulnerable adults." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 630		
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure residents' records were protected against unauthorized disclosure for electronic records. This deficient practice had the potential to affect all residents. 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).	0 700		

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0 700	Continued From page 7 The findings include: On June 27, 2023, from 6:10 a.m. through 7:30 a.m., during continuous observation, unlicensed personnel (ULP)-B failed to secure a computer with residents' private health information and access to licensee's electronic health records (EHR) for residents. ULP-B accessed each resident's medication administration record (MAR) via a laptop to verify the prescribed medications to administered to each resident. ULP-B would obtain the prescribed medications and enter each resident's private residence from an unsecured public hallway leaving the laptop on a medication cart (med cart) with the MAR and EHR still visible to all who would walk by the laptop. ULP-B repeated this practice for five (5) unique residents in 5 separate private residences. Each time ULP-B would leave the unsecured computer in the common public hallway without locking the screen and leaving resident private health information (PHI) visible to all who would walk by the computer. On June 27, 2023, at 11:00 a.m., licensed assisted living director (LALD)-C and clinical nurse supervisor (CNS)-D stated the licensee's expectation was all residents' information is secured and only accessible by authorized personnel. CNS-D stated the ULP should have locked the computer screen each time the ULP left the laptop and each ULP had been trained in this expectation. The licensee's Confidentiality of Health Information policy dated June 2020, indicated all health information would be secured and only accessible to authorized personnel only.	0 700		

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0 700	Continued From page 8 No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 700		
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) employee 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 emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees 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 employees 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	0 810		

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0 810	Continued From page 9 drill. This MN Requirement is not met as evidenced by: Based on a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements, failed to provide required employee and resident training on fire safety and evacuation, and failed to conduct required evacuation drills. This had the potential to affect all staff, residents, 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, but was not likely to cause 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). Findings include: A record review and interview were conducted on June 28, 2023, at approximately 11:30 a.m. with Maintenance (M)-I, on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not have employee actions to be taken in the event of a fire or similar emergency. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan.	0 810		

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0 810	Continued From page 10 Record review of the available documentation indicated that the evacuation plan did not include procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. The facility plan stated that the local fire department would make the determination to evacuate and go through the procedures for resident movement, evacuation, or relocation at the time of an emergency. Record review of available documentation indicated that the licensee did not provide employee training on the fire safety and evacuation plan twice per year after the training it initial hire. Record review of the available documentation indicated that the licensee did not provide annual training to residents who can assist in their own evacuation on the proper actions to take in the event of a fire to include movement, evacuation, or relocation as required by statute. During interview, M-I, verified that the fire safety and evacuation plan for the facility lacked these provisions. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01640 SS=E	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	01640		

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01640	Continued From page 11 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 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 interview and record review, the licensee failed to ensure the current service plan included a signature or other authentication by the licensee and the resident or resident's designated representative to document agreement on the services to be provided for two of four residents (R3, R4). 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 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).	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32728	A. BUILDING: _____ B. WING _____	06/30/2023

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01640	Continued From page 12 The findings include: R3 R3 was admitted on August 28, 2020. R3's Service Plan Agreement with effective date of March 1, 2023, was identified by licensed assisted living director (LALD)-C as R3's most recent signed service plan. The service plan included 24 identified services R3 received. R3's Service Plan Agreement with effective date of June 27, 2023, identified as the current service plan with all current services R3 received lacked authentication by the licensee, resident, or resident's designated representative. R3's current service plan included 31 identified services, nine (9) revised or started after March 1, 2023, and indicated a decrease in the fees for services provided compared to R3's authenticated service plan identified above. R4 R4 was admitted on December 29, 2021. R4's Service Plan Agreement with effective date of March 28, 2022, was identified by LALD-C as R4's most recent signed service plan. The service plan included 31 identified services R4 received. R4's Service Plan Agreement with effective date of June 27, 2023, identified as the current service plan with all current services R3 received lacked authentication by the licensee, resident, or resident's designated representative. R4's current service plan included 43 identified services, 38 revised or started after March 28, 2023, and indicated an increase in the fees for services provided compared to R4's authenticated service plan identified above.	01640		

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	32728	A. BUILDING: _____ B. WING _____	06/30/2023

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01640	Continued From page 13 On June 28, 2023, at 11:45 a.m., LALD-C and clinical nurse supervisor (CNS)-D stated the service plans for R3 and R4 were not authenticated when services were revised or initiated for each resident. LALD-C stated service plans should all be authenticated when revised and included in each resident's respected records. The licensee's Service Plan Agreement Development and Revision policy dated August 1, 2021, indicated services plans and all revisions would include authentication by the "client and/or the client's representative." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01760 SS=E	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.	01760		

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01760	Continued From page 14 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medication administration was documented accurately for two of four residents (R2, R4) who received medication management. 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 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: R2 R2 was admitted on July 8, 2020. R2's signed service plan dated March 1, 2023, indicated R2 received services including assistance with medication administration. R2's MAR for June 1, 2023, through June 27, 2023, indicated R2 received two Lidocaine 4 percent (%) patches applied to lower lumbar back every 24 hours to be on for 12 hours and off for 12 hours. R2's patch application was scheduled for 8:00 a.m. on the MAR. On June 27, 2023, at 7:30 a.m., the surveyor observed unlicensed personnel (ULP)-B apply the lidocaine patches to R2's lower lumbar back. The lidocaine patch applied lacked notation of the date applied and initials of ULP-B acknowledging	01760		

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01760	Continued From page 15 who and when the patch was applied. On June 27, 2023, at 12:30 p.m., clinical nurse supervisor CNS-D indicated all patches applied to residents by ULPs should include a date and initials of the ULP that applied the patch. R4 R4 was admitted on December 29, 2021. R4's signed service plan dated April 11, 2022, indicated R4 received services including assistance with medication administration. R4's medication administration record (MAR) for June 1, 2023, through June 26, 2023, indicated R4 received Novolog (fast-acting insulin) FlexPen, inject 5 units (U) subcutaneous three times daily with meals for blood sugar greater than (>) 200. R4's MAR lacked documentation when R4's blood sugar results were less than (<) 200, and Novolog insulin was ordered to be held as indicated: - 8:00 a.m. on June 3-8, 10, 12, 14-22, and 27, 2023; - 12:00 p.m. on June 3-5, 7, 10, 15-16, 18, 20, and 21, 2023; and - 5:00 p.m. on June 7, 12, and 20, 2023. On June 28, 2023, at 11:33 a.m., clinical nurse supervisor (CNS)-D indicated that R4's MAR appeared the documentation was not completed accurately for the Novolog FlexPen. CNS-D further stated confidence the insulin was held when R4's blood sugar was < 200, but it was not documented correctly. On June 28, 2023, at 11:35 a.m., regional manager (RM)-F indicated the licensee planned to work with the electronic medical record (EMR)	01760		

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01760	Continued From page 16 provider to implement a process within the program, if available, to ensure there is correct documentation when a medication was held. The licensee's Medication Documenation [sic] on the Client Medication Administration record policy revised August 1, 2021, included "The following procedure will be followed for documentation of medication assistance on the MAR or agency designated form/electronic device. 4. To document the medication administration, initial the appropriate box (or enter electronically) on the MAR form to document the medication has been administered at the appropriate time and date. All staff administering medications to a client must include the staff person's name/initials and title in the signature box on the MAR or applicable authentication." In addition, "b. Medication held - To indicate the medication was held, circle your initials on the MAR form. Include any notes regarding follow up with the nurse on the back of the MAR. If eMAR [electronic medication administration record] in use, select "not given" and indicate why the medication was not administered." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident.	01820		

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	32728	A. BUILDING: _____ B. WING _____	06/30/2023

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01820	Continued From page 17 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a complete written or electronically recorded prescriptions were obtained for one of four residents (R4). 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: R4 was admitted December 29, 2021, and received services under the Assisted Living licensure. R4's signed service plan dated April 11, 2022, indicated R4 received services including assistance with medication administration. On June 27, 2023, at 7:57 a.m., unlicensed personnel (ULP)-E was observed to administer medications to R4. R4's record included a prescription signed by provider dated May 3, 2023. R4's topical medication order and medication administration record (MAR) dated June 1, 2023, through June 26, 2023, indicated: -mometasone (used to treat skin conditions like rash and itching) 0.1% external ointment, apply 0 Grams (G) topically, daily to affected areas. R4's order lacked the amount of the topical	01820		

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01820	Continued From page 18 medication to apply, complete directions and location for use. R4's record also included a prescription signed by provider dated May 3, 2023. R4's topical medication order and MAR dated June 1, 2023, through June 26, 2023, indicated: -Tolcelyn (anti-fungal) apply to nail twice daily and avoid skin. R4's medication order lacked the strength of the medication to be administered, complete directions and location for use. On June 27, 2023, at 8:15 a.m., ULP-E stated they put the mometasone ointment to areas where the resident has a rash. ULP-E indicated the rash is on her legs now. In addition, ULP-E stated the Tolcelyn cream was placed only on R4's left big toe and both small toes. On June 27, 2023, at 8:45 a.m., clinical nurse supervisor (CNS)-D stated the directions for use on R4's medications were not clear. CNS-D agreed the orders and directions for medications needed to be clarified and then reflected on MAR accurately. CNS-D also stated she used to be a float registered nurse (RN) for another employer, and it would be frustrating if the directions were not clear. The licensee's Medication Documenation [sic] on the Client Medication Administration Record policy revised August 1, 2021, included "The following procedure will be followed for documentation of medication assistance on the MAR or agency designated form/electronic device. 1. Locate appropriate MAR sheet for the client. Staff will also refer to the MAR for medication profile listing the medication name, strength,	01820		

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01820	Continued From page 19 description, amount to be given and time of day to be given, as well as the purpose of the medication and any special instructions, if applicable. The MAR will also tell staff what side effects or problems to watch for and report." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01880 SS=E	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to store all medications in a securely locked location for two of four residents (R2, R3). 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 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:	01880		

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01880	Continued From page 20 R2 R2 was admitted for assisted living services on July 8, 2020. R2's Service Plan Agreement signed March 1, 2023, indicated R2 received assistance with medication management. R2's Medication Management Assessment dated May 12, 2023, indicated R2 required assistance with medication administration and R2's medications were kept in a locked medication cart. On June 27, 2023, at approximately 7:30 a.m., the surveyor observed one bottle of Refresh Tears Lubricant Eye Drops (common over the counter eye drop) and one bottle of Clear Eyes Redness Relief (common over the counter eye drop) on R2's bathroom counter in R2's apartment. R3 R3 was admitted for assisted living services on August 28, 2020. R3's Service Plan Agreement dated March 1, 2023, indicated R3 received assistance with medication management. R3's Medication Management Assessment dated May 12, 2023, indicated R3 required assistance with medication administration and R3's medications were kept in a locked medication cart. On June 27, 2023, at 7:00 a.m., the surveyor observed one bottle of Miralax (common medication used to treat constipation) on the kitchen counter in R3's apartment.	01880		

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	32728	A. BUILDING: _____ B. WING _____	06/30/2023

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01880	Continued From page 21 On June 27, 2023, at 12:30 p.m., clinical nurse supervisor (CNS)-D stated all medications were kept locked in medication cart with the exception if a resident had a self-administration order. CNS-D stated R2 and R3 did not have a self-administration order for any medications and should not have medications in their room. The licensee's policy Storage of Medication and Key Security dated April 19, 2023, indicated the nurse would identify where and how each resident's medications would be stored. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were maintained, including the opened date for time sensitive medication storage for one of four residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01890		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01890	Continued From page 22 safety but had the potential to have harmed a resident's health or safety) 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: R4's signed service plan dated April 11, 2022, indicated R2 received services including assistance with blood glucose monitoring and insulin administration. R4's medication administration record (MAR) for June 2023, indicated R4 received blood glucose testing three times per day, Novolog FlexPen (fast-acting insulin) 100 units per milliliter (u/ml), 5 units (u) inject subcutaneously (SQ) three times a day, for blood glucose test results more than 200, and Tresiba FlexPen (long-acting insulin) 100 u, inject 70 units SQ daily at bedtime. On June 27, 2023, at 7:57 a.m., the surveyor observed R4's medication storage and blood glucose testing supplies. Insulin and blood glucose testing supplies were stored in a locked cabinet in R4's apartment. R4's medication storage included one unopened, undated Novolog pen in a plastic bag, and a second opened Novolog pen with no open date or expiration date labeled. In addition, there were two (2) opened Tresiba pens that lacked labels to indicate the date staff first used the insulin and when the insulin would expire. On June 27, 2023, at 8:20 a.m., unlicensed personnel (ULP)-E stated the insulin pens should be dated when first opened. ULP-E was unsure why this was not documented.	01890		

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	32728	A. BUILDING: _____ B. WING _____	06/30/2023

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01890	Continued From page 23 On June 27, 2023, at 8:45 a.m., clinical nurse supervisor (CNS)-D stated the caregivers are trained to document insulin pens with date when they are opened and first used. CNS-D indicated this is something that needs to be worked on more with the ULPs. The licensee's Storage of Medication and Key Security policy dated September 27, 2021, included "When secured storage of the medications is necessary, the nurse will identify where the medications will be stored, how they will be secured or locked under proper temperature controls and who has access to the medications." The manufacturer's package insert dated June 2022, for the use of Novolog insulin directed insulin stored at room temperature should be discarded after 28 days after being opened. The manufacturer's package insert dated July 1, 2022 for the use of Tresiba insulin directed insulin stored at room temperature should be discarded after 56 days after being opened. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who	01960		

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01960	Continued From page 24 administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to document issues related to treatment administration 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 was admitted July 9, 2020. R2's Physician Orders dated May 17, 2023, indicated R2 had "localized edema" (Swelling due to an excessive accumulation of fluid at a specific anatomic site, such as lower legs) and used thromboembolic deterrent hose (abbreviated as TED hose and commonly referred to as compression stockings). R2's Service Plan Agreement dated March 1, 2023, indicated unlicensed personnel (ULP) were to provide physical assistance to apply	01960		

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01960	Continued From page 25 compression stockings daily in the morning and remove the compression stockings every night before bed. In addition, the ULP was to notify the registered nurse (RN) if the compression stockings were too tight or too loose or of any damage to the stockings. On June 27, 2023, at 7:15 a.m., surveyor observed ULP-B apply R2's compression stockings. Surveyor observed both stockings to be loose fitting. One stocking had a large run (multiple partial tears in the fibers that weaken the fabric and continue to spread into larger tears with continued use) up the back of the stocking from heel to top. The other stocking had a hole in the fabric of the heel area. R2's record lacked documentation of any reports to nursing or nursing response regarding ill-fitting damaged compression stockings. On June 27, 2023, at 11:33 a.m., clinical nurse supervisor (CNS)-D stated they were not aware of any problems with R2's compression stockings. On June 28, 2023, at 11:45 a.m. LALD-C reported they found a note indicating a ULP reported the damaged stockings approximately one week ago. The record lacked evidence of follow up from nursing. The licensee's policy Medication Documentation on the Client Medication Administration Record dated November 30, 2020, indicated the procedure for extenuating circumstances or problems with a medication/ treatment encounter would include staff notification of the problem to the nurse immediately. In addition, the policy directed staff to document in an area of the	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32728	A. BUILDING: _____ B. WING _____	06/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA ON FRANCE SENIOR LIVING	6500 FRANCE AVENUE SOUTH 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
01960	Continued From page 26 Medication Administration Record (MAR) marked as "Special Remarks", where the nurse would observe the comments and follow up. No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	01960		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property for the facility. This deficient practice had the ability to affect all staff, residents, 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, but was not likely to cause serious injury, impairment, or death), and	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32728	A. BUILDING: _____ B. WING _____	06/30/2023

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02040	Continued From page 27 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). Findings include: A record review and interview were conducted on June 28, 2023, between approximately 11:35 a.m. with Maintenance (M)-I on the hazard vulnerability assessment for the physical environment of the facility. Record review indicated that the licensee had not performed a hazard vulnerability assessment with risk and mitigation factors on and around the property. During interview, M-I stated that the licensee had performed a hazard assessment for the Appendix Z requirements but had not performed a hazard vulnerability assessment for the physical environment on or around the property and did not have any mitigation factors listed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		

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

Type: Full
Date: *06/26/23*
Time: 12:38:27
Report: 1004231046

Food and Beverage Establishment Inspection Report

Location:

Aurora On France Senior Living
6500 France Avenue South
Edina, MN55435
Hennepin County, 27

Establishment Info:

ID #: 0038742
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9528488888
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.

Surface and Equipment Sanitizers

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

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

Quaternary Ammonia: = 400PPM at Degrees Fahrenheit
Location: WIPING CLOTH BUCKET
Violation Issued: No

Food and Equipment Temperatures

Process/Item: SLICED TOMATO
Temperature: 40 Degrees Fahrenheit - Location: PREP TOP COOLER
Violation Issued: No

Process/Item: HAM
Temperature: 40 Degrees Fahrenheit - Location: PRPE TOP COOLER
Violation Issued: No

Process/Item: SAUCE
Temperature: 40 Degrees Fahrenheit - Location: COOLER #4
Violation Issued: No

Process/Item: BACON
Temperature: 41 Degrees Fahrenheit - Location: COOLER #4
Violation Issued: No

Food and Beverage Establishment Inspection Report

Process/Item: FISH
Temperature: 169 Degrees Fahrenheit - Location: STEAM WELL
Violation Issued: No

Process/Item: COOKED VEGETABLE MIX
Temperature: 158 Degrees Fahrenheit - Location: STEAM WELL
Violation Issued: No

Process/Item: MILK
Temperature: 38 Degrees Fahrenheit - Location: COOLER #2
Violation Issued: No

Process/Item: SOUP
Temperature: 186 Degrees Fahrenheit - Location: SOUP WELL
Violation Issued: No

Process/Item: SOUP
Temperature: 38 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: CUT LETTUCE
Temperature: 40 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: PASTA
Temperature: 40 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: MILK
Temperature: 39 Degrees Fahrenheit - Location: COOLER #5
Violation Issued: No

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

INSPECTION WAS CONDUCTED BY MOLLY DOUGHERTY (FPLS) IN CONJUNCTION WITH A HEALTH REGULATIONS DIVISION (HRD) SURVEY CONDUCTED BY BRANDON MUELLER.

DISCUSSED:
-EMPLOYEE ILLNESS POLICY AND LOG
-HANDWASHING
-SANITIZER USE AND TEST KITS
-CLEANING/SANITIZING FOOD CONTACT SURFACES AND UTENSILS
-HIGH TEMPERATURE SANITIZING DISH MACHINE TEMPERATURE VERIFICATION
-DATE MARKING PROCEDURES
-COOLING PROCEDURES
-REHEATING PROCEDURES
-THERMOMETER USE AND CALIBRATION
-SERVING A HIGHLY SUSCEPTIBLE POPULATION (NO RAW/UNDERCOOKED ANIMAL FOODS, NO UNPASTEURIZED JUICE, MILK, ETC)
-VOMIT/FECAL INCIDENT CLEAN UP PROCEDURES
-FOOD SOURCE
-RECEIVING DELIVERIES PROCEDURES

-FOOD SERVICE PROCEDURES
-PEST CONTROL
-LOGS (COOLER TEMPERATURE, COOKING TEMPERATURES, COOLING TEMPERATURES, SANITIZER CONCENTRATIONS, ETC)
-PHYSICAL FACILITIES AND MAINTENANCE

*HIGH TEMPERATURE SANITIZING DISH MACHINE WAS BEING SERVICED AT THE TIME OF THE INSPECTION AND WAS NOT OPERABLE.

*IF ANY RESIDENT COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE RESIDENT, OR CALL ON THEIR BEHALF. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.

*NO VIOLATIONS OBSERVED DURING TIME OF INSPECTION

*REPORT WAS DISCUSSED WITH THE DIRECTOR OF NUTRITION, LYDIA, AND WITH THE NURSE EVALUATOR, BRANDON.

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 1004231046 of 06/26/23.

Certified Food Protection Manager: TRIDEY MAYES

Certification Number: FM27194 Expires: 08/23/24

Signed: _____
LYDIA B.
DIRECTOR OF NUTRITION

Signed: Molly Dougherty
Molly Dougherty
Public Health Sanitarian
Metro District Office
651-201-3978
molly.dougherty@state.mn.us