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	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aurora on France	6500 France Avenue Edina, MN 55435

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to promote and maintain dignity for 1 of 3 residents reviewed for dignity (R29) when staff directed a continent resident to roll over and have a bowel movement in his brief rather than assessing and implementing toileting interventions consistent with his needs, preferences, and dignity. The facility failed to ensure assessments, care plans, and staff practices provided clear direction regarding R29's toileting status and preferences, despite documentation identifying him as continent of bowel and bladder and his expressed distress regarding having bowel movements in bed. This had the potential to cause psychosocial harm, loss of dignity, and diminished quality of life by failing to respect the resident's autonomy, preferences, and right to receive care in a dignified manner. Findings include: R29's admission Minimum Data Set (MDS), dated [DATE], indicated he was admitted to the facility on [DATE] and was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15. R29's toileting care plan, initiated 4/24/26 and revised 4/27/26, identified him as totally dependent and directed staff to use a bedpan and/or brief for toileting, clothing management, and hygiene. Additional care plan interventions directed staff to toilet him as requested and as needed and noted he needed assistance with a urinal. A separate incontinence care plan, initiated 4/28/26, directed staff to provide incontinence care according to the bowel and bladder assessments and after incontinence episodes. However, review of a bowel and bladder assessment dated [DATE] identified R29 as continent of both bowel and bladder. The assessment contained no documented bowel habits. R29's transferring care plan, initiated 4/24/26 and revised 4/29/26, indicated R28 was totally dependent on staff and using a full body mechanical lift for all transfers. R29's Kardex continued to direct staff to provide incontinent care following episodes of incontinence despite the bowel and bladder assessment identifying him as continent. The conflicting assessments and care planning failed to provide clear direction regarding whether R29 was continent and should be assisted to toilet or incontinent and managed through routine brief changes. During interview on 5/26/26 at 2:52 PM, R29 reported he used a urinal but required staff assistance. He stated he had experienced accidents while waiting for staff to respond. He described having a bowel movement in bed as the most demoralizing part of my whole life. R29 stated staff had never offered or discussed transferring him to a toilet using a mechanical lift despite his awareness and continence. During interview on 5/27/26 at 1:03 PM, nursing assistant (NA)-B stated R29 previously requested a bedpan but currently used a brief and urinal. NA-B stated that on the day of the interview, R29 had a bowel movement in his brief and called for assistance. NA-B stated she told him he would have an easier time having a bowel movement if he rolled onto his side in bed. NA-B further stated he transferred with a mechanical lift and did not transfer to the toilet. During interview on 5/27/26 at 1:58 PM, registered nurse (RN)-E stated R29 was continent and called staff when he needed a bedpan or urinal. RN-E stated staff positioned the urinal, covered him for privacy, and left the room. RN-E further stated therapy had been completing bathroom transfer training using pivot transfers. RN-E acknowledged a specialty toileting sling was available and could be used to transfer residents to a toilet but stated R29 did not use the sling. The nurse's description of R29 as continent (continued on next page)

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.

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and capable of participating in toileting activities conflicted with care plan and Kardex directions identifying him as incontinent and directing staff to provide routine brief care.During interview on 5/28/26 at 8:18 AM, nurse manager and registered nurse (RN)-F stated that toileting expectations for a continent resident who required a mechanical lift depended on the resident's preferences. RN-F stated residents could use a bedpan or be assisted to a toilet if they wished to get out of bed and staff attempted to respect resident choices. Regarding R29, RN-F stated he preferred a bedpan for bowel movements and a urinal for bladder needs and would use the call light to request assistance. RN-F stated she had offered to assist R29 to the toilet; however, he expressed concerns about safety and believed he needed to improve further before attempting toilet transfers. When informed that a nursing assistant reported telling R29 to roll onto his side and have a bowel movement in his brief, RN-F stated, We would not say that and indicated such a statement would be a coachable moment. During interview on 5/28/26 at 9:54 AM, the director of nursing (DON) stated dignified toileting practices included use of a bedpan when needed. The DON stated it was not the standard of care expected by the facility to tell a resident to roll over and have a bowel movement in bed. The DON's statement supported that directing R29 to have a bowel movement in his brief did not align with facility expectations for preserving resident dignity. A facility policy titled Dignity, dated 3/2025, indicated the facility promoted care for residents in a manner that enhanced each resident's dignity and respect in full recognition of their individuality.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure a self-administration of medications (SAM) assessment was completed to allow resident to safely administer own medications for 1 of 1 (R1) resident observed with medications at bedside. Findings include:R1's comprehensive Minimum Data Set (MDS) dated [DATE], indicated R1 was cognitively intact, needed substantial/maximal assistance with toileting hygiene, upper/lower body dressings, bed mobility, transfers, and needed moderate assistance with oral and personal hygiene. R1 was dependent on staff for bathing. R1's diagnosis report dated 5/28/26, indicated diagnosis of pneumonia, acute respiratory failure with hypoxia, hypertensive heart failure, diabetes, anxiety disorder, and chronic low back pain. R1's physician orders dated 5/28/26 included orders for clobetasol propionate external ointment 0.05% (a topical steroid) with directions to apply to labia, distal left wall topically in the evening every Monday, Wednesday, Friday for Lichen Planus (chronic non-contagious inflammatory condition where the immune system mistakenly attacks cells in the skin, hair, nails or genital mucosa). Apply a pea sized amount 3 times weekly. Apply to the inside of the labia and distal left wall of vagina. R1's Medication Administration Record (MAR) dated May 2026, indicated the cream was administered by the staff as ordered. R1's nursing admission assessment dated [DATE], included a question about self-administration of medication and the answer was documented as not applicable.During interview on 5/26/26 at 4:35 p.m., R1 stated she had a vaginal rash, and over a week ago the staff lost her medicated cream (clobetasol). R1 stated first they lost the cream's labeled plastic bag, then they couldn't find the cream. R1 said her husband brought her the clobetasol cream she had at home. During the interview, the clobetasol cream was on top of her nightstand. The clobetasol's box was labeled by a local pharmacy with R1's information. R1 stated she had been applying the cream every day to the affected area, and as needed. During interview on 5/27/26 at 12:41 p.m., registered nurse (RN)-E stated residents can self- administer medications if they are alert and oriented, and after a self-administration of medication (SAM) assessment was completed. RN-E added, the facility also needed a doctor's order.During interview on 5/27/26 at 12:51 p.m., RN-H stated she was not aware R1 had a medicated cream in her room. RN-H looked in the medication cart for the cream and was not there. RN-H retrieved the cream from R1's room and stated she will need a SAM assessment and provider's order to self-administer the medicated cream, and they would need to re-order the medicated cream from our pharmacy. During interview on 5/27/26 at 1:00 p.m., nurse manager RN-F stated before a resident was allowed to self-administer a medication a procedure needed to be followed. RN-F stated a SAM assessment needed to be completed, and the staff needed to obtain a doctor's order for SAM and to be okay to leave medication at bedside. During interview on 5/28/26 at 10:32 a.m., the director of nursing (DON) stated staff needed to screen the resident's cognition, complete a SAM, and contact the provider to obtain an order. DON stated the expectation was no medications will be left at bedside without proper assessment and orders. Facility's policy titled Self Administration of Medications dated 9/2024, indicated the policy of this facility was to establish uniform guidelines concerning the self-administration of drugs in compliance with federal regulations. The policy's procedure indicated a SAM will be completed for any resident requesting to administer any medication without the direct supervision of a nurse. The attending physician's order will be signed and dated prior to self-administration and left at bedside. The medication kept at bedside must be stored in a locked box, attached to something that can't be easily moved. Nurses will educate the resident on the proper use of medications.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to offer a written notice of transfer which included a statement of the resident's appeal rights and the contact information of the Office of the State Long-Term Care Ombudsman. In addition, the facility failed to provide written information on the duration of the bed-hold, and reserve bed payment for 2 of 3 residents (R51, R69) reviewed for hospitalizations. Findings include: R51 R51's admissions Minimum Data Set, dated [DATE] identified R51 with intact cognition, had no functional impairment, required assistance with toileting, dressing, and showering. In addition, R51 had diagnoses of congestive heart failure, heart disease, arthritis, depression, and chronic lung disease. During record review of R51's electronic medical record (EMR) R51 was hospitalized on [DATE] following a fall in his room. He was sent to the hospital and remained until 5/18/26 when he was transferred back to the facility. During interview with registered nurse (RN)-A on 5/28/26 at 6:58 a.m., RN-A stated expectation of staff to print out a face sheet, orders, and medication list to transfer resident to hospital. RN-A stated she was unaware of providing a written transfer and bed hold form. During interview with RN-B on 5/28/26 at 7:09 a.m., RN-B stated expectation of staff to print out a face sheet, orders, and medication list to transfer resident to hospital. RN-B stated nothing was written or signed by the resident on transfer. During interview with R51 on 5/28/26 7:19 a.m., R51 stated he was not offered or provided a verbal or written transfer or bed hold form. During interview with licensed practical nurse (LPN)-A on 5/28/26 at 7:22 a.m., LPN-A stated expectation of staff to print out a face sheet, orders, and medication list to transfer resident to hospital. We do not have them sign the bedhold or transfer form. R69 R69's admission Minimum Data Set (MDS) assessment dated [DATE], indicated R69 had intact cognition with no hallucinations, delusions, or behaviors. R69's progress note dated 3/16/26 at 3:15 p.m., indicated R69 was transferred to the emergency department by ambulance, as R69 had said she was now ready to go. R69's medical record was reviewed, and an indication that a written transfer notice, which included information such as the ombudsman information and the resident's appeal rights, was given on transfer to the hospital was not found. Indication that R69 had been given a written bed-hold notice (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that included information such as the duration of the state bed-hold policy, the reserve bed payment policy, or the nursing facility's policy regarding bed-hold periods, on transfer to the hospital was not found. During an interview on 5/27/26 at 12:15 p.m., registered nurse (RN)-E stated she sent documents such as the order summary, medication administration record, etc., but did not give a written transfer notice, which included information like ombudsman information and appeal rights, or a written bed hold notice. RN-E stated she believed that social services would follow up with the resident later to see if they would like to hold their bed. During an interview on 5/27/26 at 1:15 p.m., RN-F, the nurse manager for the unit, stated she did not believe they had a process in place to give residents a written notice of transfer, which included information like ombudsman information and appeal rights, or bed hold on transfer to the hospital, although social services did follow up with residents after transfer to see if they would like to hold their bed. During an interview on 5/28/26 at 9:44 a.m., the director of nursing (DON) deferred questions regarding written transfer and bed-hold notices to the assistant administrator (AA). During an interview on 5/28/26 at 9:53 a.m., the AA stated that staff might go through a written bed hold notice with the resident before transfer to the hospital, depending on their responsiveness status. The AA stated otherwise, the social services department would contact the resident or representative at a later time to determine if they would like their bed hold. The AA stated the expected process would be for these conversations to be documented in a progress note, but he wasn't sure how often this was happening. The AA stated he believed the facility had a form that could be given on transfer that included things such as the ombudsman and appeal information but was not sure if staff were giving out this form on transfer to the hospital. The AA stated that if this form was given, he would expect it to be scanned into the electronic medical record, but he did not see it for R69. The facility's Transfer and Discharge from the Facility policy dated 1/22/25, indicated that the Notice of Transfer or Therapeutic Leave would be given to the resident or representative at the time of transfer. The policy indicated this would be documented in the resident's record. The policy indicated that if the resident representative was not present at the time of transfer, nursing staff would contact them and notify them of the transfer and clarify the status of the bed hold. The policy indicated that on the first business day following the resident's transfer, social services staff should continue to attempt to reach the representative to clarify the bed-hold status. The policy indicated that social services staff should document the resident's bed hold status in the electronic medical record and should send the notice of transfer, along with the bed hold notice, to the representative for signature. The policy indicated social services would then scan these notices into the electronic health record.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure a discharge return anticipated (DRA) Minimum Data Set (MDS) was transmitted for 1 of 3 residents (R42) and a discharge return not anticipated (DRNA) MDS was transmitted for 1 of 1 residents (R8), to the Centers for Medicare and Medicaid (CMS) reviewed for no MDS record in 120 days.Findings include: R42's admission MDS dated [DATE], indicated R42 had a discharge- return anticipated and it was unplanned. The MDS indicated the assessment was completed but did not indicate the assessment was submitted to CMS. The MDS included under the submit section, do not submit to CMS. R42's Census listing dated 12/11/25, indicated R42 admitted to the nursing home on [DATE], and their status changed to STOP BILLING on 12/11/25. R42's progress note dated 12/11/25 at 2:56 a.m., indicated R42 was discharged to the emergency department due to a fall. R8's DRNA MDS dated [DATE], indicated R8 had a discharge- return not anticipated and it was planned. The MDS indicated the assessment was completed but did not indicate the assessment was submitted to CMS. The MDS included under the submit section, do not submit to CMS. R8's Census listing dated 1/6/26, indicated R8 admitted to the nursing home on [DATE], and their status changed to STOP BILLING on 1/6/26. R8's progress note dated 1/6/26 at 12:57 p.m., indicated R8 was discharged with family to an ILF. During an interview on 5/27/26 at 12:36 p.m., registered nurse (RN)-D, an MDS coordinator, confirmed she had reviewed R42's record and stated that it looked like a DRA assessment had been completed but never sent to CMS. RN-D confirmed she had reviewed R8's record and stated that a DRNA assessment had been completed but also had never been sent to CMS. The facilities MDS/Care Plan Process/Resident Assessment policy dated 10/21/25, indicated that when MDS forms are completed directly on the facility's computer, each assessor signs and dates it, after it is reviewed for accuracy. The policy did not include the expected time frame for submitting DRA/DRNA MDS's to CMS.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure a level I Pre-admission Screening (PAS) and, if needed, a Level II Pre-admission Screening and Resident Review (PASARR) was completed to screen for mental health needs for 1 of 1 residents (R45) reviewed for PAS.Findings include: R45's admission Minimum Data Set (MDS) dated [DATE], indicated R45 was admitted to the facility on [DATE] and had intact cognition. The MDS indicated R45 was diagnosed with anxiety and bipolar disorder. R45's PAS notice dated 4/22/26, indicated a copy of the PAS was included with this notice, but the PAS was not final until the lead agency sent a final determination to the nursing facility. R45's medical record was reviewed and lacked evidence that a final determination from the lead agency had been received. During an interview on 5/27/26 at 2:13 p.m., the admissions coordinator (AC) stated that when a resident was admitted from the hospital, the hospital would complete a PAS, and the screening would then be sent to them. The AC stated that generally she would reach out to the lead agency, and they would sometimes send the final PAS. The AC confirmed that they did see the final PAS from the lead agency, which was Medica, after reviewing R45's medical record. The AC stated she did not keep documentation on any attempts to reach out to the lead agency for the final PAS. During an interview on 5/28/26 at 9:50 a.m., the administrator stated that admissions was in charge of receiving the PAS and then following up as needed to obtain the final PAS. The facility's PASARR Level I & II policy dated 10/2017, indicated that prior to a resident's admission, the admissions coordinator or designee would ensure the PASARR Level I screening was completed and received. The admissions coordinator or designee would then work with the appropriate community provider to ensure completion of the PASARR level I screening form and verification was received. The policy indicated that the PASARR Level I would be scanned into the resident's medical record.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Based on observation, interview, and document review, the facility failed to ensure routine/as-needed nail trimming and cleaning was completed for 1 of 1 residents (R13) reviewed for nail care who required staff assistance with their activities of daily living (ADLs).Findings include: R13's admission Minimum Data Set (MDS) 4/10/26, indicated R13 had intact cognition and was diagnosed with paraplegia (the partial or complete paralysis of the lower half of the body) and not diabetes. The MDS indicated R13 required setup/clean-up assistance with eating, supervision or touching assistance with oral hygiene and personal hygiene, and was dependent on staff for toileting hygiene, bathing, lower body dressing, and putting on and taking off footwear. R13's care plan dated 4/6/26, indicated a weekly body audit was to be performed. The care plan indicated R13 required setup/clean-up assistance with eating, supervision or touching assistance with oral hygiene and personal hygiene, and was dependent on staff for toileting hygiene, bathing, lower body dressing, and putting on and taking off footwear. R13's Weekly Bath and Skin Sheet dated 5/9/26, 5/17/26, and 5/23/26, included a section titled Nail Care with a box checked indicating R13's fingernails were short and smooth and did not need trimming. No further completed Weekly Bath and Skin Sheets were found. After reviewing R13's medical record, documentation indicating R13 had received nail care while at the facility before the survey start was not found. During an interview and observation on 5/26/26 at 11:59 a.m., R13 was observed in bed with his fingernails over 1/4 of an inch beyond the end of his fingertip with a brown substance underneath the tips of his fingernails. R28 stated he did not have a fingernail clipper and was unsure if he would be able to cut them by himself anyway. R28 stated he had wanted his nails trimmed for a while, but the staff had not offered to assist him with trimming them. During an observation and interview on 5/27/26 at 10:09 a.m., R13 was observed with fingernails over 1/4 of an inch beyond the end of his fingertip with a brown substance underneath the tips of his fingernails. R13 stated that no one had offered to help him cut or clean his fingernails. During an interview and observation on 5/27/26 at 1:42 p.m., nursing assistant (NA)-A confirmed he was the aide assisting R13 during the day shift. NA-A stated that R13 required assistance with his activities of daily living, and he did not think R13 would be able to cut his nails by himself. When asked about the appearance of R13's nails, NA-A was unsure. NA-A was observed to enter R13's room and stated R13's nails looked pretty long, and he thought it was not likely they were short on 5/23/26. NA-A confirmed he had not offered to help R13 complete nail care. During an interview on 5/28/26 at 7:41 a.m., registered nurse (RN)-G stated that the aides should assist the residents with trimming and cleaning their nails on shower days and as needed. RN-G stated that generally, nails would be something the aides would look at, but if the nurse notices that they were long or dirty, they could then delegate nail care to the aide. RN-G stated that if the nurse happened to notice the nail status, they would document this on the weekly bath sheet, but usually the aides would look at a resident's nail status and relay that to the nurse to document. During an interview on 5/28/26 at 9:42 a.m., the director of nursing (DON) stated that nursing staff should be checking resident nail status and trimming and cleaning as needed and on bath days, if indicated. The DON stated that the nurses should be assessing the resident's nail status themselves on bath days to ensure it is accurate. The facility's Care of Nails policy dated 6/20/25, indicated nail care should be completed on bath days and as needed.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to implement hospital discharge recommendations and facility standing orders for daily weight monitoring for a resident with a primary diagnosis of congestive heart failure (CHF). The facility also failed to assess and implement a low-sodium diet recommendation, failed to monitor for weight changes indicative of fluid retention, and failed to develop a care plan addressing CHF management after the resident's diuretic therapy was placed on hold pending further clinical evaluation for 1 of 1 residents (R84) reviewed for quality of care.Findings include: Findings include:R84's admission Minimum Data Set (MDS) assessment, dated 5/5/26, identified R84 had mild cognitive impairment and a primary diagnosis of chronic congestive heart failure (CHF - a condition where the heart cannot pump blood well often resulting in excess fluid buildup in the body).R84's electronic medical record (EMR) revealed a documented weight of 270 pounds on 5/4/26.R84's hospital Interagency Transfer Form - Physician Orders discharge paperwork dated 5/21/26 indicated R84 was admitted to the hospital on [DATE] with a weight of 210 pounds and diagnosis of edema of left upper extremity.R84's Discharge summary dated [DATE] indicated R84 received IV Lasix (furosemide, a medication used to treat fluid retention) during the hospital stay and transitioned to oral Lasix for edema, however, the orders directed R84 should pause taking it until your doctor or other care provider tells you to start again. The discharge paperwork included signed orders for daily weights, provider notification for a weight gain of 2 pounds in one day and/or 5 pounds in one week, and a low sodium diet. R84's weight at discharge on [DATE] was 169 pounds.R84's facility Orders included Ok for Standing House Orders starting 5/21/26.The facility Standing Orders for Nursing Facilities and Skilled Nursing Facilities 2026 signed 2/3/26, included Daily weights for patients with Heart Failure and call for > 3lb weight gain in 24 hours or 5lbs in one week unless otherwise ordered.R84's weight was documented at 153 pounds on 5/23/36.R84's medical record lacked evidence of daily weight monitoring, instructions for provider notification, and ordered diet following re-admission to the facility.R84's comprehensive care plan failed to identify congestive heart failure as a focus area and lacked interventions related to CHF management, daily weight monitoring, fluid status monitoring, sodium restriction, or monitoring for signs and symptoms of worsening heart failure. During interview on 5/27/26 at 1:03 p.m., nursing assistant (NA)-B stated staff learned how to care for residents through the Kardex, (which was based off the comprehensive care plan), the nurse, or the manager. NA-B was unable to provide insight regarding specific care provided to R84. During interview on 5/28/26 at 7:51 a.m., licensed practical nurse (LPN)-C stated daily weights would be documented in the Medication Administration Record (MAR). LPN-C stated residents generally received monthly, weekly, or daily weights depending on medications or clinical needs and stated nursing assistants completed weights through nurse delegation.During interview on 5/28/26 at 8:18 a.m., nurse manager and registered nurse (RN)-F stated the hospital discharge recommendations for daily weights and a low-sodium diet should have been followed. RN-F stated daily weights would normally be documented on the Treatment Administration Record (TAR) and stated the dietitian would review dietary recommendations and place them on the resident's meal ticket. When asked how staff would determine when to restart furosemide without daily weight monitoring, RN-F stated the provider would monitor laboratory values and staff would observe the resident. RN-F acknowledged staff had not routinely monitored R84's weight as directed by the discharge paperwork. RN-F later stated a diagnosis of CHF would not necessarily require daily weights and stated staff would instead monitor vital signs daily. During interview on 5/28/26 at 9:54 a.m., the Director of Nursing (DON) stated the facility's standing orders included daily weights for residents with CHF; however, not every resident required implementation of those orders. The DON stated nurse managers were responsible for determining which recommendations and interventions should be initiated following admission. The DON further stated unit health coordinators would not (continued on next page)

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	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aurora on France	6500 France Avenue Edina, MN 55435

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	necessarily review discharge recommendations unless a specific physician order had been entered and stated nurse managers were responsible for determining which discharge recommendations were most important for each resident.During interview on 5/28/26 at 10:23 a.m., the dietitian stated the facility provided low-sodium diets and followed physician orders for dietary restrictions.A facility policy on Heart Failure monitoring was requested; however, the facility did not have this specific policy.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to provide pharmaceutical services that ensured medications were available to meet residents' needs for 2 of 5 residents reviewed for medication administration (R29 and R57). This deficient practice resulted in multiple prescribed medications being unavailable for administration and created the potential for residents to miss ordered medications or receive doses that differed from the physician's prescribed regimen. Findings include: R29's admission Minimum Data Set (MDS), dated [DATE], indicated he was admitted to the facility on [DATE] and was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15. R57's admission Minimum Data Set (MDS), dated [DATE], indicated he was admitted to the facility on [DATE] and was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 13. During observation and interview on 05/27/2026 at 8:01 a.m., RN-E conducted a medication pass for R29 and identified four medications that were unavailable for administration, including ginkgo biloba, a multivitamin with minerals, vitamin B12, and vitamin E. RN-E checked the medication cart and available house stock but was unable to locate the medications. RN-E stated she would need to fax and call the pharmacy to ensure the medications were delivered that day and reported medications generally should be reordered when the supply reached the last row of a medication card or when there was still a few days of the medication left giving time for the medication to be delivered before it ran out. RN-E stated the assistant administrator, who was also filling the supplier role, reordered house stock medications. RN-E further stated she would need to notify the provider regarding the unavailable medications because they were vitamins and not considered urgent. RN-E stated, So I am missing 4 different med, that's a lot. During observation and interview on 05/28/2026 at 7:51 a.m., LPN-C conducted a medication pass for R57 and was unable to locate cyclosporine ophthalmic drops ordered for administration. LPN-C stated the medication should have been reordered when the supply reached the last package of eye drops and reported she would administer the resident's other medications and continue searching because mornings were busy. During the same medication pass, LPN-C identified that the resident's ordered losartan 75 mg was unavailable and only losartan 50 mg was present. LPN-C stated the resident should have had one 50 mg tablet and one 25 mg tablet available for administration and reported she had called the pharmacy twice during her previous shift on Tuesday regarding the missing medication.During a follow-up interview on 05/28/2026 at 9:50 a.m., LPN-C stated she obtained a one-time order from the nurse practitioner to administer losartan 50 mg in place of the prescribed losartan 75 mg because the ordered dose was unavailable. LPN-C stated staff were not permitted to split tablets to achieve the ordered dose.During interview on 05/28/2026 at 8:18 a.m., the nurse manager and RN-F stated the expectation was for the nurse administering the medication to reorder it when approximately seven days of supply remained. RN-F stated staff were expected to fax refill requests to the pharmacy and follow up by telephone to confirm receipt of the fax. RN-F stated pharmacy staff sometimes responded that refill requests were submitted too early and at other times reported they had not received the faxed request. RN-F stated nurses did not always have time to call the pharmacy to verify receipt of refill requests and acknowledged, it should not be that way, but life happens.A pharmacy policy titled Ordering and Receiving Medication from the Dispensing Pharmacy, dated 9/10/24, indicated refill request of current medications should be placed 5-7 days before the current supply runs out to ensure to gaps in medication administration.