Protecting, Maintaining and Improving the Health of All Minnesotans

AMENDED

Electronically Delivered

May 15, 2025

Licensee
Prairie Bluffs Senior Living
10300 Hennepin Town Road
Eden Prairie, MN 55347

RE: Project Number(s) SL35561016

Dear Licensee:

Please Note: This is an amended notice to accompany the revised State Form amending tag 0100. Reference to the previously held Informal Conference has also been removed from this notice. No other changes have been made.

The Minnesota Department of Health (MDH) completed a survey on February 12, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35561	A. BUILDING: _____ B. WING _____	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE BLUFFS SENIOR LIVING	10300 HENNEPIN TOWN ROAD EDEN PRAIRIE, MN 55347

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL35561016-0 On February 10, 2025, through February 12, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 86 residents; 86 receiving services under the Assisted Living Facility with Dementia Care license. On May 14, 2025, tag identification 0100 was amended. The licensee was notified.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 100 SS=F	144G.10 Subdivision 1 License required (a)(1)Beginning August 1, 2021, no assisted living	0 100		

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0 100	Continued From page 1 facility may operate in Minnesota unless it is licensed under this chapter. (2) No facility or building on a campus may provide assisted living services until obtaining the required license under paragraphs (c) to (e). (b)The licensee is legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. Nothing in this chapter shall in any way affect the rights and remedies available under other law. (c) Upon approving an application for an assisted living facility license, the commissioner shall issue a single license for each building that is operated by the licensee as an assisted living facility and is located at a separate address, except as provided under paragraph (d) or (e). (d) Upon approving an application for an assisted living facility license, the commissioner may issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility. An assisted living facility license for a campus must identify the address and licensed resident capacity of each building located on the campus in which assisted living services are provided. (e) Upon approving an application for an assisted living facility license, the commissioner may: (1) issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility with dementia care, provided the assisted living facility for dementia care license for a campus identifies the buildings operating as assisted living facilities with dementia care; or (2) issue a separate assisted living facility with dementia care license for a building that is on a campus and that is operating as an assisted living facility with dementia care.	0 100		

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0 100	Continued From page 2 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee was not legally responsible for the management, control, and operation of the whole facility in which the licensee allowed use of the assisted living facility space to operate third party outpatient therapy services. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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). The findings include: During the entrance conference on February 10, 2025, at approximately 11:00 a.m., licensed assisted living director (LALD)-A stated the licensee was familiar with current minimum assisted living requirements. On February 10, 2025, from 11:15 a.m., through 11:55 a.m., the surveyor toured the facility campus with LALD-A and clinical nurse supervisor (CNS)-B and observed the following: -the campus consisted of two buildings (an assisted living building licensed for 100 beds and a building with 45 unlicensed independent living apartments) connected by a skyway on the second and third floors. -each building had a separate main entrance and	0 100		

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0 100	Continued From page 3 building access through an underground garage; -on the main floor of the assisted living building, a physical therapy gym was located at the end of a hallway on a resident care unit. LALD-A stated the physical therapy gym was operated by a third party and provided services to residents of the facility as well as non-residents on an out-patient basis. The licensee's Application for Assisted Living License, signed on May 28, 2021, indicated the following: - page 1, the physical address of the facility was 10300 Hennepin Town Road, Eden Prairie, Minnesota 55347. - page 2, the assisted living license would be structured as one building at one address with one property identification number. - Page 5, the authorized agent who had signed the assisted living license application indicated they had read the Minnesota Statue, chapter 144G and Minnesota Rules, chapter 4659, governing the provision of assisted living facilities, and understood as a licensee, they would be legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 100		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the	0 480		

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0 480	Continued From page 4 Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition;	0 480		

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0 480	Continued From page 5 (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated February 11, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		

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0 550	Continued From page 6	0 550		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure to include contact information for the facility individuals responsible for handling complaints, the Office of Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints (OHFC) at the Minnesota Department of Health (MDH). This had the potential to affect all residents receiving assisted living services. 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	0 550		

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0 550	Continued From page 7 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On February 10, 2025, at 11:45 a.m., during the facility tour, the surveyor observed a grievance posting in the common area of the facility. The grievance posting lacked the following required information: - the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances; -the contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities; and - the contact information for the OHFC at MDH. On February 12, 2025, at 10:58 a.m., licensed assisted living director (LALD)-A stated the required contact information was not included in the grievance posting. LALD-A stated the posting would be corrected. On February 12, 2025, at 12:15 p.m., the surveyor was provided an updated grievance posting with the required information (corrected during the survey). The licensee's 2.09 Complaint/Grievance policy dated February 11, 2022, read "to ensure complaints regarding [licensee] are resolved in a timely and appropriate manner for employees or residents that have concerns or complaints." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 550		

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0 550	Continued From page 8 (21) days	0 550		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included baseline screening and testing for one of two employees (unlicensed personnel (ULP)-C). 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	0 660		

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0 660	Continued From page 9 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee's Facility TB Risk Assessment dated July 18, 2024, indicated the licensee was a low risk for TB. ULP-C was hired October 18, 2021, and began providing assisted living services. ULP-C's employee record included a TB history and symptom screen dated November 2, 2021, and documentation of a tuberculin skin test (TST) given on November 2, 2021. ULP-C's employee record lacked documentation of a required second TST. On February 12, 2025, at 10:58 am., licensed assisted living director (LALD)-A stated ULP-C did not have a second TST completed. LALD-A stated ULP-C was sent that morning for a QuantiFERON Gold test (a blood test for TB). The Minnesota Department of Health (MDH) guidelines Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, read "an employee may begin working with patients (residents) after a negative TB history and symptom screen (no symptoms of active TB disease) and a IGRA (a serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record."	0 660		

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0 660	Continued From page 10 The licensee's 8.16 Tuberculosis Screening policy revised July 16, 2024, indicated all new employees would have a TB blood test or a TST conducted with results documented on the Baseline TB Screening Tool for Health Care Workers. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the current Minnesota Fire Code Provisions. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During facility tour on February 11, 2025, from 9:00 a.m. through 10:58 a.m. with licensed	0 775		

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0 775	Continued From page 11 assisted living director (LALD)-A and maintenance assistant (MA)-F, the surveyor observed fire rated doors in the following locations that did not self-close and latch: Ninety-minute fire rated doors in second floor corridor to independent living did not fully close and latch. Twenty-minute fire rated doors in second floor corridor by resident room 228 did not latch. Twenty-minute fire rated door into resident room 119 did not fully close and latch. Twenty-minute fire rated door in life enrichment office had a door closer mounted to the door. The closer arm was removed so the door did not self-close. All the resident rooms in the enhanced care wing had twenty-minute fire rated doors with a door closer mounted to the door. The closer arm was removed so the door did not self-close. Ninety-minute fire rated door in basement trash room had a door closer mounted to the door. The closer arm was removed so the door did not self-close. Fire rated doors must be maintained to automatically close and latch as designed, to prevent the spread of smoke and fire to adjoining building areas. During same tour the surveyor observed the basement trash chutes had sliding doors held open with chains that were equipped with fusible links to enable the doors to automatically close in the event of fire. The fusible links were broken	0 775		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 775	Continued From page 12 and bypassed so the doors would not self-close in the event of fire. Trash chute doors must be maintained to automatically close as designed, to prevent the spread of smoke and fire to adjoining building areas and floors. LALD-A and MA-F verified the above conditions during the tour and stated they understood the requirements. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
01060 SS=E	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section	01060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35561	A. BUILDING: _____ B. WING _____	02/12/2025

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01060	Continued From page 13 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation lasting more than four days for two of two 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 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).	01060		

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01060	Continued From page 14 The findings include: R2 R2 was admitted on March 19, 2022, and began receiving assisted living services. R2's record included an Attachment E: Service Plan dated August 30, 2024, indicating R2's services included assistance with dressing and bathing, medication administration, transfers, safety checks, and oxygen management. R2's record included a progress note dated June 17, 2024, indicating R2's condition declined, and she was transported to the hospital. The progress notes indicated R2 returned from the hospital after 15 days, on July 2, 2024, at 5:52 p.m. R3 R3 was admitted on March 6, 2024, and began receiving assisted living services. R3's record included an Attachment E: Service Plan dated January 7, 2025, indicating R3's services included medication administration, blood glucose monitoring, and assistance with compression stockings. R3's record included a progress note dated January 3, 2025, at 10:35 a.m., indicating resident's condition had declined and she was taken to the hospital and returned to the facility on January 7, 2025, at 1:10 p.m. R3's progress note dated January 11, 2025, at 5:04 p.m., indicated resident was taken to the hospital after falling in her apartment the day prior. As of the closing date of this survey, the resident had not yet returned to the facility.	01060		

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01060	Continued From page 15 R2 and R3's records lacked evidence of a written notice provided to the resident, the residents' legal representative, designated representative, and OOLTC that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident had been relocated and any new service provider; - contact information for the OOLTC; - if known and applicable, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement that a return date was not currently known; and - a statement that, if the facility refused to provide housing or services after a relocation, the resident had the right to appeal and the contact information for the agency to which the resident may submit an appeal. On February 12, 2025, at approximately 10:30 a.m., clinical nurse supervisor (CNS)-B stated they were unable to locate an emergency relocation notification for R2 and R3. CNS-B stated the relocation notices may not have been completed. The licensee's 1.23 Emergency Relocation policy dated July 29, 2021, read: "1. In the event of an emergency relocation, [licensee] will provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care. (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and	01060		

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01060	Continued From page 16 (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
01880 SS=F	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 and interview, the licensee failed to 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 had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On February 10, 2025, at approximately 12:00	01880		

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01880	Continued From page 17 p.m., during a facility tour with licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B, the surveyor observed an unattended and unlocked medication cart in the third-floor memory care unit. The medication cart was locked by the surveyor and witnessed by LALD-A. On February 10, 2025, at 12:12 p.m., the surveyor and CNS-B observed an unattended and unlocked medication cart on the second-floor memory care unit. The cart was locked by CNS-B On February 10, 2025, at 12:12 p.m., CNS-B stated all medication carts were to be locked when they were unattended. CNS-B stated they were not sure why the staff were not locking the carts, and that additional training would be provided. The licensee's 7.11 Medication Storage policy dated August 1, 2021, read "medications managed outside of a resident's private 'living space' must be in securely locked and substantially constructed compartments and permit only authorized personnel to have access. This may be a medication room, medication cart, or similar setup". No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In	02170		

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02170	Continued From page 18 addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individualized activities and preferences plan contained all required content for three of three residents (R1,	02170		

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02170	Continued From page 19 R5, R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 was admitted June 20, 2024, and began receiving assisted living services. R1's diagnoses included Alzheimer's disease and R1 resided in the secured dementia care unit. R5 was admitted September 19, 2022, and began receiving assisted living services. R5's diagnoses included Alzheimer's disease and R5 resided in the secured dementia care unit. R6 was admitted on January 17, 2022, and began receiving assisted living services. R6's diagnoses included Alzheimer's disease and R6 resided in the dementia care unit. On February 11, 2025, at 12:30 p.m., clinical nurse supervisor (CNS)-B provided Getting to Know You Activity Assessments for R1, R5, and R6. The activity assessment for R1 was dated June 18, 2024, and the activity assessments for R5 and R6 were undated. The activity assessments for R1, R5, and R6 lacked the following required content: -current abilities and skills; -emotional and social needs and patterns; -physical abilities and limitations;	02170		

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02170	Continued From page 20 -identification of activities for behavioral interventions; -an individual activity plan based on the resident's activity evaluation; and -a selection of daily structured and non-structured activities to be included on the residents' activity plan. On February 12, 2025, at 12:16 p.m., licensed assisted living director (LALD)-A stated the current activity assessments were used for all memory care residents and lacked required content. LALD-A stated they would be updating the assessments and were advocating to get them into an online format. The licensee's 3.05 ALDC Life Enrichment Programs, Activities, and Outdoor Space policy dated August 1, 2021, indicated each resident would be evaluated for activities according to the licensing rules of the facility. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02170		

Electronically Delivered

March 19, 2025

Licensee
Prairie Bluffs Senior Living
10300 Hennepin Town Road
Eden Prairie, MN 55347

RE: Project Number(s) SL35561016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 12, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

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

The correction order documentation should include the following:

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

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

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

INFORMAL CONFERENCE
In accordance with Minn. Stat. § 144G.20, Subd. 20, the Commissioner of Health is authorized to hold a conference to exchange information, clarify issues, or resolve issues. The Department of Health staff would like to schedule a conference call with Prairie Bluffs Senior Living. Please contact Jess Schoenecker at 651-201-3789 on or before Monday, March 24, 2025, to schedule the conference call.

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

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

If you have any questions, please contact me.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

JMD

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0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL35561016-0 On February 10, 2025, through February 12, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 86 residents; 86 receiving services under the Assisted Living Facility 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 Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 100 SS=F	144G.10 Subdivision 1 License required (a)(1)Beginning August 1, 2021, no assisted living	0 100		

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0 100	Continued From page 1 facility may operate in Minnesota unless it is licensed under this chapter. (2) No facility or building on a campus may provide assisted living services until obtaining the required license under paragraphs (c) to (e). (b)The licensee is legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. Nothing in this chapter shall in any way affect the rights and remedies available under other law. (c) Upon approving an application for an assisted living facility license, the commissioner shall issue a single license for each building that is operated by the licensee as an assisted living facility and is located at a separate address, except as provided under paragraph (d) or (e). (d) Upon approving an application for an assisted living facility license, the commissioner may issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility. An assisted living facility license for a campus must identify the address and licensed resident capacity of each building located on the campus in which assisted living services are provided. (e) Upon approving an application for an assisted living facility license, the commissioner may: (1) issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility with dementia care, provided the assisted living facility for dementia care license for a campus identifies the buildings operating as assisted living facilities with dementia care; or (2) issue a separate assisted living facility with dementia care license for a building that is on a campus and that is operating as an assisted living facility with dementia care.	0 100		

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0 100	Continued From page 2 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee was not legally responsible for the management, control, and operation of the whole facility in which the licensee had provided assisted living services to residents when the licensee had independent living apartments not included under the assisted living licensure and allowed use of the assisted living facility space to operate third party outpatient therapy services. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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). The findings include: During the entrance conference on February 10, 2025, at approximately 11:00 a.m., licensed assisted living director (LALD)-A stated the licensee was familiar with current minimum assisted living requirements. On February 10, 2025, from 11:15 a.m., through 11:55 a.m., the surveyor toured the facility campus with LALD-A and clinical nurse supervisor (CNS)-B and observed the following: -the campus consisted of two buildings (an assisted living building licensed for 100 beds and	0 100		

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0 100	Continued From page 3 a building with 45 unlicensed independent living apartments) connected by a skyway on the second and third floors. Skyway entrances had double doors with magnetic door holds and 90-minute fire safety ratings. -each building had a separate main entrance and building access through an underground garage; -on the main floor of the assisted living building, a physical therapy gym was located at the end of a hallway on a resident care unit. LALD-A stated the physical therapy gym was operated by a third party and provided services to residents of the facility as well as non-residents on an out-patient basis. The licensee's website dated 2025, indicated the licensee's address was 10300 Hennepin Town Road, offering independent living, assisted living, memory care, and enhanced assisted living options. The licensee's Application for Assisted Living License, signed on May 28, 2021, indicated the following: - page 1, the physical address of the facility was 10300 Hennepin Town Road, Eden Prairie, Minnesota 55347. - page 2, the assisted living license would be structured as one building at one address with one property identification number. - Page 5, the authorized agent who had signed the assisted living license application indicated they had read the Minnesota Statue, chapter 144G and Minnesota Rules, chapter 4659, governing the provision of assisted living facilities, and understood as a licensee, they would be legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract.	0 100		

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	35561	A. BUILDING: _____ B. WING _____	02/12/2025

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0 100	Continued From page 4 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 100		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage;	0 480		

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

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0 480	Continued From page 6 Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated February 11, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure to include contact information for the facility individuals responsible for handling complaints,	0 550		

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0 550	Continued From page 7 the Office of Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints (OHFC) at the Minnesota Department of Health (MDH). This had the potential to affect all residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On February 10, 2025, at 11:45 a.m., during the facility tour, the surveyor observed a grievance posting in the common area of the facility. The grievance posting lacked the following required information: - the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances; -the contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities; and - the contact information for the OHFC at MDH. On February 12, 2025, at 10:58 a.m., licensed assisted living director (LALD)-A stated the required contact information was not included in the grievance posting. LALD-A stated the posting would be corrected. On February 12, 2025, at 12:15 p.m., the surveyor was provided an updated grievance posting with the required information (corrected	0 550		

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0 550	Continued From page 8 during the survey). The licensee's 2.09 Complaint/Grievance policy dated February 11, 2022, read "to ensure complaints regarding [licensee] are resolved in a timely and appropriate manner for employees or residents that have concerns or complaints." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers	0 660		

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0 660	Continued From page 9 for Disease Control and Prevention (CDC) which included baseline screening and testing for one of two employees (unlicensed personnel (ULP)-C). 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: The licensee's Facility TB Risk Assessment dated July 18, 2024, indicated the licensee was a low risk for TB. ULP-C was hired October 18, 2021, and began providing assisted living services. ULP-C's employee record included a TB history and symptom screen dated November 2, 2021, and documentation of a tuberculin skin test (TST) given on November 2, 2021. ULP-C's employee record lacked documentation of a required second TST. On February 12, 2025, at 10:58 am., licensed assisted living director (LALD)-A stated ULP-C did not have a second TST completed. LALD-A stated ULP-C was sent that morning for a QuantiFERON Gold test (a blood test for TB). The Minnesota Department of Health (MDH) guidelines Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013,	0 660		

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0 660	Continued From page 10 and based on CDC guidelines, read "an employee may begin working with patients (residents) after a negative TB history and symptom screen (no symptoms of active TB disease) and a IGRA (a serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record." The licensee's 8.16 Tuberculosis Screening policy revised July 16, 2024, indicated all new employees would have a TB blood test or a TST conducted with results documented on the Baseline TB Screening Tool for Health Care Workers. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the current Minnesota Fire Code Provisions. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 775		

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0 775	Continued From page 11 safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During facility tour on February 11, 2025, from 9:00 a.m. through 10:58 a.m. with licensed assisted living director (LALD)-A and maintenance assistant (MA)-F, the surveyor observed fire rated doors in the following locations that did not self-close and latch: Ninety-minute fire rated doors in second floor corridor to independent living did not fully close and latch. Twenty-minute fire rated doors in second floor corridor by resident room 228 did not latch. Twenty-minute fire rated door into resident room 119 did not fully close and latch. Twenty-minute fire rated door in life enrichment office had a door closer mounted to the door. The closer arm was removed so the door did not self-close. All the resident rooms in the enhanced care wing had twenty-minute fire rated doors with a door closer mounted to the door. The closer arm was removed so the door did not self-close. Ninety-minute fire rated door in basement trash room had a door closer mounted to the door. The closer arm was removed so the door did not self-close.	0 775		

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0 775	Continued From page 12 Fire rated doors must be maintained to automatically close and latch as designed, to prevent the spread of smoke and fire to adjoining building areas. During same tour the surveyor observed the basement trash chutes had sliding doors held open with chains that were equipped with fusible links to enable the doors to automatically close in the event of fire. The fusible links were broken and bypassed so the doors would not self-close in the event of fire. Trash chute doors must be maintained to automatically close as designed, to prevent the spread of smoke and fire to adjoining building areas and floors. LALD-A and MA-F verified the above conditions during the tour and stated they understood the requirements. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
01060 SS=E	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider;	01060		

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01060	Continued From page 13 (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation lasting more than four days for two of two residents (R2, R3).	01060		

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01060	Continued From page 14 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 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 March 19, 2022, and began receiving assisted living services. R2's record included an Attachment E: Service Plan dated August 30, 2024, indicating R2's services included assistance with dressing and bathing, medication administration, transfers, safety checks, and oxygen management. R2's record included a progress note dated June 17, 2024, indicating R2's condition declined, and she was transported to the hospital. The progress notes indicated R2 returned from the hospital after 15 days, on July 2, 2024, at 5:52 p.m. R3 R3 was admitted on March 6, 2024, and began receiving assisted living services. R3's record included an Attachment E: Service Plan dated January 7, 2025, indicating R3's services included medication administration, blood glucose monitoring, and assistance with compression stockings. R3's record included a progress note dated	01060		

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01060	Continued From page 15 January 3, 2025, at 10:35 a.m., indicating resident's condition had declined and she was taken to the hospital and returned to the facility on January 7, 2025, at 1:10 p.m. R3's progress note dated January 11, 2025, at 5:04 p.m., indicated resident was taken to the hospital after falling in her apartment the day prior. As of the closing date of this survey, the resident had not yet returned to the facility. R2 and R3's records lacked evidence of a written notice provided to the resident, the residents' legal representative, designated representative, and OOLTC that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident had been relocated and any new service provider; - contact information for the OOLTC; - if known and applicable, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement that a return date was not currently known; and - a statement that, if the facility refused to provide housing or services after a relocation, the resident had the right to appeal and the contact information for the agency to which the resident may submit an appeal. On February 12, 2025, at approximately 10:30 a.m., clinical nurse supervisor (CNS)-B stated they were unable to locate an emergency relocation notification for R2 and R3. CNS-B stated the relocation notices may not have been completed. The licensee's 1.23 Emergency Relocation policy dated July 29, 2021, read: "1. In the event of an emergency relocation, [licensee] will provide a	01060		

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01060	Continued From page 16 written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care. (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
01880 SS=F	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 and interview, the licensee failed to 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 had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a	01880		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE BLUFFS SENIOR LIVING	10300 HENNEPIN TOWN ROAD EDEN PRAIRIE, MN 55347

(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
01880	Continued From page 17 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 February 10, 2025, at approximately 12:00 p.m., during a facility tour with licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B, the surveyor observed an unattended and unlocked medication cart in the third-floor memory care unit. The medication cart was locked by the surveyor and witnessed by LALD-A. On February 10, 2025, at 12:12 p.m., the surveyor and CNS-B observed an unattended and unlocked medication cart on the second-floor memory care unit. The cart was locked by CNS-B On February 10, 2025, at 12:12 p.m., CNS-B stated all medication carts were to be locked when they were unattended. CNS-B stated they were not sure why the staff were not locking the carts, and that additional training would be provided. The licensee's 7.11 Medication Storage policy dated August 1, 2021, read "medications managed outside of a resident's private 'living space' must be in securely locked and substantially constructed compartments and permit only authorized personnel to have access. This may be a medication room, medication cart, or similar setup".	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35561	A. BUILDING: _____ B. WING _____	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE BLUFFS SENIOR LIVING	10300 HENNEPIN TOWN ROAD EDEN PRAIRIE, MN 55347

(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
01880	Continued From page 18 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities;	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35561	A. BUILDING: _____ B. WING _____	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE BLUFFS SENIOR LIVING	10300 HENNEPIN TOWN ROAD EDEN PRAIRIE, MN 55347

(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
02170	Continued From page 19 (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individualized activities and preferences plan contained all required content for three of three residents (R1, R5, R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 was admitted June 20, 2024, and began receiving assisted living services. R1's diagnoses included Alzheimer's disease and R1 resided in the secured dementia care unit. R5 was admitted September 19, 2022, and began receiving assisted living services. R5's diagnoses included Alzheimer's disease and R5 resided in the secured dementia care unit. R6 was admitted on January 17, 2022, and began receiving assisted living services. R6's diagnoses included Alzheimer's disease and R6 resided in the dementia care unit. On February 11, 2025, at 12:30 p.m., clinical	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35561	A. BUILDING: _____ B. WING _____	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE BLUFFS SENIOR LIVING	10300 HENNEPIN TOWN ROAD EDEN PRAIRIE, MN 55347

(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
02170	Continued From page 20 nurse supervisor (CNS)-B provided Getting to Know You Activity Assessments for R1, R5, and R6. The activity assessment for R1 was dated June 18, 2024, and the activity assessments for R5 and R6 were undated. The activity assessments for R1, R5, and R6 lacked the following required content: -current abilities and skills; -emotional and social needs and patterns; -physical abilities and limitations; -identification of activities for behavioral interventions; -an individual activity plan based on the resident's activity evaluation; and -a selection of daily structured and non-structured activities to be included on the residents' activity plan. On February 12, 2025, at 12:16 p.m., licensed assisted living director (LALD)-A stated the current activity assessments were used for all memory care residents and lacked required content. LALD-A stated they would be updating the assessments and were advocating to get them into an online format. The licensee's 3.05 ALDC Life Enrichment Programs, Activities, and Outdoor Space policy dated August 1, 2021, indicated each resident would be evaluated for activities according to the licensing rules of the facility. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02170		

Minnesota Department of Health
Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
6512014500

Type: Follow-Up
Date: *02/18/25*
Time: 10:00:00
Report: 1047251040

Food and Beverage Establishment Inspection Report

Location:

Prairie Bluffs Senior Living
10300 Hennepin Town Road
Eden Prairie, MN55347
Hennepin County, 27

Establishment Info:

ID #: 0038747
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9524445000
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: = 300 ppm at Degrees Fahrenheit
Location: Sanitizer bucket
Violation Issued: No

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

All previous violations have been corrected.

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 1047251040 of 02/18/25.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____
Rick Brass
PIC

Signed:_____
Holly Sievers
Public Health Sanitarian 2
Metro Office
6512015946
Holly.Sievers@state.mn.us

Minnesota Department of Health
Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
6512014500

Type: Full
Date: *02/11/25*
Time: 11:00:00
Report: 1047251035

Food and Beverage Establishment Inspection Report

Location:
Prairie Bluffs Senior Living
10300 Hennepin Town Road
Eden Prairie, MN55347
Hennepin County, 27

Establishment Info:
ID #: 0038747
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9524445000
ID #:

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

The following orders were issued during this inspection.

4-500 Equipment Maintenance and Operation

4-501.114C3 ***** Priority 1 *****

MN Rule 4626.0805C3 Provide and maintain an approved quaternary ammonium compound sanitizing solution in water with 500 ppm hardness or less, a minimum temperature of 75 degrees F (24 degrees C) and a concentration specified in 21CFR.178.1010 and as indicated by the manufacturer's use directions and label.

QUAT SANITIZER CONCENTRATION WAS LESS THAN MANUFACTURER'S REQUIREMENT OF 200 PPM. FACILITY STATED THEY WOULD CONTACT HILLIARD TO INCREASE THE SANITIZER CONCENTRATION FOR THEIR DISPENSER.

Comply By: 02/11/25

4-600 Cleaning Equipment and Utensils

4-601.11A ***** Priority 2 *****

MN Rule 4626.0840A Equipment food-contact surfaces and utensils must be clean to sight and touch.
BUILD UP OF CRUMBS/FOOD DEBRIS OBSERVED ON TOASTER.
Comply By: 02/11/25

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.113B

MN Rule 4626.1575B Store maintenance and cleaning equipment in an orderly manner that facilitates the cleaning of the storage area.
REMOVE EXTRA/UNNECESSARY EQUIPMENT IN MEMORY CARE KITCHENS
Comply By: 02/11/25

Surface and Equipment Sanitizers

Hot Water: = at 168 Degrees Fahrenheit
Location: Mem. Care 3rd Floor
Violation Issued: No

Hot Water: = at 166 Degrees Fahrenheit
Location: Mem. Care 2nd Floor
Violation Issued: No

Hot Water: = at 164 Degrees Fahrenheit
Location: Kitchen Dishmachine
Violation Issued: No

Hot Water: = 50 ppm at Degrees Fahrenheit
Location: Sanitizer bucket
Violation Issued: Yes

Hot Water: = 50 ppm at Degrees Fahrenheit
Location: 3 comp sink dispenser
Violation Issued: Yes

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: Kitchen refrigerator- salad dressing
Violation Issued: No

Process/Item: Cooking
Temperature: 183 Degrees Fahrenheit - Location: Kitchen- fish
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: Prep cooler- turkey
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: Small cooler- juice
Violation Issued: No

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: 2nd Floor mem care- milk
Violation Issued: No

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: 3rd floor mem care- sausage
Violation Issued: No

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

Inspection was completed with R. Brass & J. Shuveller, and reviewed with MDH Nurse Evaluator M. Winters.

Senior living facility has a commercial kitchen and a coffee/bistro area on the main floor. Memory care kitchenettes are on the second and third floor of facility. Coffee/bistro not currently in use.

Type: Full
Date: *02/11/25*
Time: 11:00:00
Report: 1047251035
Prairie Bluffs Senior Living

Food and Beverage Establishment Inspection Report

Discussed handwashing, warewashing, employee illness policy, temperature control, final cook temperatures, cleaning, serving highly susceptible populations, and food handling procedures.

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 1047251035 of 02/11/25.

Certified Food Protection Manager Chelsea R. Kalal

Certification Number: FM108332 Expires: 10/28/27

Inspection report reviewed with person in charge and emailed.

Signed:_____

Rick Brass
PIC

Signed:_____

Holly Sievers
Public Health Sanitarian 2
Metro Office
6512015946
Holly.Sievers@state.mn.us