Electronically Delivered

October 20, 2022

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

RE: Project Number(s) SL35561015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on September 21, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health 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.

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

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

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

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction 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 issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

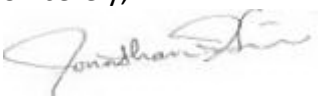
A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should be addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,



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Email: jonathan.hill@state.mn.us
Telephone: 651-592-5119 Fax: 651-215-9697

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 _____	09/21/2022

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 Initial comments *****ATTENTION****** ASSISTED LIVING 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: SL35561015 On, September 19, 2022, through September 21, 2022, the Minnesota Department of Health conducted a survey at the above provider and the following correction orders are issued. At the time of the survey, there were 67 residents, all of whom received services under the provider's Assisted Living/with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living with Dementia Care 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.	

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0 650	Continued From page 1	0 650		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee record included all required content for two of two employees (unlicensed personnel (ULP)-C,	0 650		

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0 650	Continued From page 2 ULP-D) with records reviewed. 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-C ULP-C was hired on July 14, 2021 to provide direct care services. ULP-C's employee record lacked evidence ULP-C completed all the required training, and demonstrated competency in the following topics: - appropriate and safe techniques in personal hygiene and grooming - hair care and bathing - care of teeth, gums, and oral prosthetic devices - dressing and assisting with toileting - standby assistance techniques and how to perform them - reading and recording temperature, pulse, and respirations of the client - safe transfer techniques and ambulation - range of motion and positioning - administering medications or treatments as required - Other RN/professionally delegated tasks (e.g., monitor vital signs, catheter, or stoma care, Broda chair, mechanical lifts). During an interview on September 20, 2022, at approximately 2:15 p.m., director of nursing (DON)-B- stated ULP-C was trained and	0 650		

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0 650	Continued From page 3 competency tested in the topics listed above but lacked documentation of above training. On September 20, 2022, at approximately 2:30 p.m., DON-B provided ULP-C's supervision of staff evaluation dated August 6, 2021. ULP-D ULP-D was hired to provide assisted living services on May 7, 2022. ULP-D's employee record did not contain documentation of a job description provided to ULP-D. On September 20, 2022, at approximately 3:30 p.m., licensed assisted living director (LALD)-A verified ULP-D's record lacked a job description and stated the licensee's policy required a job description in the employee file. The licensee's Associate Records policy dated August 1, 2021, indicated associate records will include all training and in-service education required and/or provided including record of competency testing. The licensee's Personnel Files/Employee Records policy, dated January 27, 2017, directed the employee file contain a current job description. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control	0 660		

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0 660	Continued From page 4 (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 record review and interview, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The licensee failed to ensure symptom screening and testing for active TB (either a two-step tuberculin skin test (TST) or blood test) were completed and documented for two of two employees (unlicensed personnel (ULP)-D, ULP-C) with employee records reviewed. This had the potential to affect all 67 residents receiving assisted living services, 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	0 660		

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0 660	Continued From page 5 or has the potential to affect a large portion or all the residents). The findings include: ULP-D ULP-D was hired by the licensee on May 7, 2022, to provide direct care services. ULP-D's employee record lacked: - current documentation of a completed health history and TB symptom screening; - completion of a two-step TST or other evidence of TB screening such as a blood test upon hire. On September 20, 2022, at approximately 3:30 p.m., licensed assisted living director (LALD)-A verified ULP-D's required TB screening and testing was not completed. ULP-C ULP-C was hired by the licensee on July 14, 2021, to provide direct care services. ULP-C's employee record lacked a current documentation of a completed health history and TB symptom screening. On September 20, 2022, at approximately 3:35 p.m., LALD-A verified ULP-C's required TB health history and TB symptom screening was not completed. The licensee's Tuberculosis Screening policy, effective August 1, 2021, indicated the agency would establish and maintain a TB prevention and control program based on the most current guidelines issued by the Center for Disease Control and Prevention (CDC). The policy indicated staff would be screened and tested for tuberculosis prior to the staff being exposed to	0 660		

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0 660	Continued From page 6 residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by:	0 680		

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0 680	Continued From page 7 Based on observation, interview and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all required content. This had the potential to affect all 67 residents receiving assisted living services, staff, and visitors. In addition, the licensee failed to perform the frequency of inspection, maintenance, and load test requirements for the emergency power generator as part of the emergency plan to ensure the proper performance of the generator that serves the enhanced care unit. 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: EMERGENCY PREPAREDNESS PLAN During the entrance conference on September 19, 2022, at approximately 10:00 a.m., a surveyor requested to view the licensee's EPP, which was later reviewed by the surveyor. On September 20, 2022, at approximately 10:45 a.m., licensed assisted living director (LALD)-A provided the licensee's incomplete EPP and verified this plan lacked some components. The licensee's EPP lacked the following required content: -process for emergency preparedness (EP) cooperation with state and local EP	0 680		

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0 680	Continued From page 8 officials/organizations. -EP training and testing program; and -annual EP testing requirements. EMERGENCY GENERATOR On September 20, 2022, at approximately 3:45 p.m., survey staff interviewed LALD-A about the emergency generator and requested records relating to the emergency generator inspections, maintenance, and load test runs from LALD-A for review. Record review indicated the licensee failed to provide the required minimum frequency of weekly inspections, maintenance, and monthly load test records as required to meet the requirements for the emergency power generator as outlined under NFPA 110, (referenced under the Code of Federal Regulations, title 42, section 483.73) as part of the facility's emergency plan required under Minnesota Rules, Part 4659.0100, to ensure proper performance of the generator. LALD-A provided a record for review of the generator load test last performed on April 20, 2020, and no other records were available. On September 20, 2022, at approximately 3:45 p.m., LALD-A acknowledged the finding that the load tests, maintenance, and inspection records on the emergency generator were not met. The licensee's Emergency Preparedness policy, dated July 26, 2021, indicated the licensee would have in place a general emergency preparedness plan that will comply with federal emergency preparedness regulations. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		

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0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings are: On September 20, 2022, approximately from 11:00 a.m. to 2:15 p.m., survey staff toured the facility with the director of maintenance (DM-G), the chief of operations (CO)-F, and the marketing director (DOM)-E. During the tour, survey staff observed the following: FIRE-RATED DOORS:	0 800		

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0 800	Continued From page 10 1. The 90-minute fire-rated set doors at the 3rd-floor skyway failed to latch when closed for proper occupancy separation protection from the independent apartment skyway link. 2. The 90-minute fire-rated 3rd-floor stairway door (near skyway) failed to latch when closed for proper fire protection of vertical opening. 3. The fire-rated door for the trash/recycling room on the 3rd floor failed to latch when closed for hazardous area protection. 4. The 20-minute fire-rated door for the 2nd-floor sensory room had a missing self-closing arm to protect and maintained the smoke-tight integrity of the corridor. 5. The 90-minute fire-rated door between the enhanced care and the assisted living part of the main floor of the building was wedged in an open position preventing the door to close during a fire as designed. Survey staff explained to the CO-F, DM-G, and the DOM-E that all fire-rated doors must be in proper working order to maintain the integrity of the fire safety plan and fire-rated doors must be able to close to protect against the spread of smoke and flames to compartmentalize the building to protect the residents, staff, and visitors. RESIDENT APARTMENT UNIT #330 In unit #330, the space opening between the deck vertical guard rail and the exterior building wall had an excessive opening at approximately between 5 to 5.5 inches which exceeded the maximum allowed opening for deck use safety. On September 20, 2022, at approximately 3:45 p.m., during the exit interview, the LALD-A acknowledged the above findings.	0 800		

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0 800	Continued From page 11 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation	0 810		

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 _____	09/21/2022

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
0 810	Continued From page 12 drill. This MN Requirement is not met as evidenced by: Based on documentation review and interview, the licensee failed to provide the minimum number of evacuation drills and the required employee and resident on fire safety training. This has the potential to directly affect the safety of residents receiving care, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 20, 2022, at approximately 2:15 p.m. survey staff received the facility fire safety and evacuation plan and related documentation for review from the licensed assisted living director (LALD)-A. Document review and interview with the LALD-A at approximately 3:45 p.m. indicated the following findings: TRAINING 1) Documentation review indicated the licensee failed to provide employee training on the fire safety and evacuation plan upon hire and twice per year thereafter. No training records were provided for review. 2) Document review indicated that the licensee did not provide annual training to residents who can assist in their evacuation on the proper actions to take in the event of a fire including	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 810	Continued From page 13 movement, evacuation, or relocation. No resident training record was provided for review. EVACUATION DRILLS Document review indicated the licensee failed to provide the minimum required fire and evacuation drills for compliance of two drills per year per shift with at least one drill every other month for a total minimum of six evacuation drills per year. The drill record review showed the last fire drills performed this year were on January 31, 2022, that covered for all three work shifts on the same day. In addition, the fire drill records for January lacked evacuation drill information. Survey staff explained that employee fire drills must also include evacuation drills and fire and evacuation drills may be performed at the same time. On September 20, 2022, at approximately 3:45 p.m., during the exit interview, the LALD-A acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 810		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff	01440		

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 _____	09/21/2022

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01440	Continued From page 14 performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to ensure the registered nurse (RN) conducted direct supervision of staff performing delegated nursing or therapy tasks within 30 days of first providing those services for one of two employees (unlicensed personnel (ULP)-D) with employee records reviewed. 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: ULP-D was hired to provide assisted living services on May 7, 2022.	01440		

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01440	Continued From page 15 The employee record of ULP-D did not contain documentation that ULP-D had been supervised after performing delegated tasks. On September 20, 2022, at approximately 3:30 p.m. licensed assisted living director (LALD)-A verified there was no documentation that ULP-D had been supervised after performing delegated tasks. The licensee's Personnel Files/Employee Records policy, dated January 27, 2017, directed the employee record contain evidence of completed registered nurse evaluations of staff for delegated nursing services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01540 SS=F	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete.	01540		

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 _____	09/21/2022

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01540	Continued From page 16 Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received the required hours of dementia care training for two of two employees (unlicensed personnel (ULP)-D, 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) 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: ULP-D ULP-D was hired on May 7, 2022, to provide direct care services to the licensee's residents. The employment record of ULP-D lacked documentation of the required eight hours of initial dementia care training within 80 working hours of the employment start date. On September 20, 2022, at approximately 3:30 p.m., licensed assisted living director (LALD)-A confirmed ULP-D had not completed the required initial dementia care training. The licensee's Dementia Training policy, dated August 1, 2021, indicated direct care employees must have completed eight hours of initial	01540		

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01540	Continued From page 17 dementia training within 80 hours of employment start date. ULP-C ULP-C was hired on July 14, 2021, to provide direct care services to the licensee's residents. The employment record of ULP-C lacked documentation of the required two hours of annual dementia care training. On September 20, 2022, at approximately 3:30 p.m., LALD-A confirmed ULP-C had not completed the required annual dementia care training. The licensee's Dementia Training policy, dated August 1, 2021, indicated all staff will complete two (2) hours of additional dementia care training for each 12 months of work. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		

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

Type: Full
Date: *09/19/22*
Time: 11:00:00
Report: 8041221278

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.

3-500B Microbial Control: hot and cold holding

3-501.16A2 ** Priority 1 **

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

TIME/TEMPERATURE CONTROL FOR SAFETY (TCS) FOOD IN THE UPRIGHT COOLER IN THE SECOND FLOOR MEMORY KITCHEN MEASURED 48-50 DEG F. TCS FOOD WERE STOCKED BEFORE LUNCH SERVICE AND MOVED TO A DIFFERENT COOLER DURING INSPECTION.

Comply By: 09/19/22

4-300 Equipment Numbers and Capacities

4-302.13B ** Priority 2 **

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

NO IRREVERSIBLE REGISTERING TEMPERATURE INDICATOR ON SITE FOR MEASURING THE UTENSIL SURFACE TEMPERATURE FOR THE DISH MACHINES. OPTIONS DISCUSSED DURING INSPECTION.

Comply By: 09/26/22

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

ESTABLISHMENT DOES NOT HAVE A CURRENT CERTIFIED FOOD PROTECTION MANAGER. MANAGER THAT WILL BE STARTING SOON HAS CERTIFICATE.

Comply By: 10/03/22

3-500A Microbial Control: cooling

3-501.13E

MN Rule 4626.0380E Remove frozen fish from the reduced oxygen package prior to thawing under refrigeration or immediately after thawing if using the running water method of thawing.

REDUCED OXYGEN PACKAGES OF SALMON IN THE WALK-IN COOLER NOT OPENED WHEN TAKEN OUT OF THE FREEZER TO THAW. PACKAGES WERE OPENED DURING INSPECTION.

Comply By: 09/19/22

4-200 Equipment Design and Construction

4-204.112A

MN Rule 4626.0620A Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.

LINE COOLER IN THE MAIN KITCHEN DOES NOT HAVE A THERMOMETER.

Comply By: 09/26/22

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

UPRIGHT COOLER IN THE SECOND FLOOR KITCHEN IS RUNNING WARM (50 DEG. F). AJUST/REPAIR.

Comply By: 09/19/22

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

MEMORY CARE SERVING AREA HAND SINKS DO NOT HAVE A HANDWASHING SIGN OR POSTER.

Comply By: 09/26/22

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400 ppm at Degrees Fahrenheit
Location: front sani bucket
Violation Issued: No

Quaternary Ammonia: = 400 ppm at Degrees Fahrenheit
Location: 3 compartment sink
Violation Issued: No

Utensil Surface Temp.: = at 165 Degrees Fahrenheit
Location: main kitchen dish machine
Violation Issued: No

Utensil Surface Temp.: = at 162 Degrees Fahrenheit
Location: 2nd floor dish machine
Violation Issued: No

Utensil Surface Temp.: = at 160 Degrees Fahrenheit
Location: 3rd floor dish machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Hot Holding
Temperature: 176 Degrees Fahrenheit - Location: front counter soup well: chicken vegtable
Violation Issued: No

Process/Item: Cooking
Temperature: 175 Degrees Fahrenheit - Location: fryer: fried chicken
Violation Issued: No

Process/Item: Hot Holding
Temperature: 159 Degrees Fahrenheit - Location: warmer: fried chicken
Violation Issued: No

Process/Item: Cold Holding
Temperature: 36 Degrees Fahrenheit - Location: line cooler: sliced tomato
Violation Issued: No

Process/Item: Cold Holding
Temperature: 36 Degrees Fahrenheit - Location: line cooler: potato salad
Violation Issued: No

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: 2 door cooler: cut melon
Violation Issued: No

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: 2 door cooler: hard boiled egg
Violation Issued: No

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: back prep cooler: garlic butter
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: walk-in cooler: cranberry chicken salad
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: walk-in cooler: pork
Violation Issued: No

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: 2nd floor serving area cooler: milk
Violation Issued: No

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding
Temperature: 48 Degrees Fahrenheit - Location: 2nd floor kitchen cooler: hard boiled egg
Violation Issued: Yes

Process/Item: Cold Holding
Temperature: 50 Degrees Fahrenheit - Location: 2nd floor kitchen cooler: cut melon
Violation Issued: Yes

Process/Item: Cold Holding
Temperature: 35 Degrees Fahrenheit - Location: 3rd floor serving area cooler: milk
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: 3rd floor serving area cooler: sour cream
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	1	1	5

Inspection was completed with Howard Williams (Chef) and Trish (Executive Director). Mary Bruess and Robyn Woolley were the Nurse Evaluators present completing site survey.

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 is currently only used for ice cream socials on Fridays. A continental breakfast is set up on counter outside of the main kitchen every day except Wednesday. There are currently 64 residents on site.

Discussed the following:
Employee illness policy and logging requirements
Glove-use and bare hand contact
Handwashing
Restrictions concerning serving a highly susceptible population
Vomit clean up procedures
Date marking requirements
Cooling and re-heating procedures
Violations on this report

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 8041221278 of 09/19/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____
Trish Martenson
Executive Director

Signed: Sarah Conboy
Sarah Conboy
Public Health Sanitarian III
651-201-3984
sarah.conboy@state.mn.us