Electronically Delivered

December 16, 2024

Licensee
Pioneer Estates
8761 Preserve Boulevard
Eden Prairie, MN  55344

RE:  Project Number(s) SL32608016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on November 8, 2024, 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.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

**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 . . ."

**IMPOSITION OF FINES**

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

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

Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

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

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

**DOCUMENTATION OF ACTION TO COMPLY**

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

The correction order documentation should include the following:

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

**CORRECTION ORDER RECONSIDERATION PROCESS**

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by 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**

**REQUESTING A HEARING**

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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: SL32608016
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 |
|---|---|---|---|
| | 32608 | A. BUILDING: _____ B. WING _____ | 11/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIONEER ESTATES | 8761 PRESERVE BOULEVARD EDEN PRAIRIE, MN 55344 |

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| 0 000 | Initial Comments<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>SL32608016<br><br>On November 4, 2024, throught November 8, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were twenty-three residents receiving services under the Assisted Living Facility 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.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>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. | |
| 0 110 SS=C | 144G.10 Subdivision 1a Assisted living director license required | 0 110 | | |

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| 0 110 | Continued From page 1<br><br>Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record (DOR) for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors.<br><br>This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) 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 the residents).<br><br>The findings include:<br><br>A review of the Board of Executives for Long Term Services and Supports (BELTSS) website (https://nha.hlb.state.mn.us/#/services/onlineEntitySearch) revealed on November 4, 2024, at 7:00 a.m., indicated a previous employee for the licensee was listed as the licensee's DOR.<br><br>On November 4, 2024, at 10:30 a.m., during the entrance conference with clinical nurse supervisor (CNS)-A, house manager (HM)-C, and director of operations (DOO)-F) identified HM-C was the licensee's interim LALD for the licensee.<br><br>During interview on November 4, 2024. at 10:40 | 0 110 | | |

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| 0 110 | Continued From page 2<br><br>a.m., HM-C stated the previous DOR ended their employment on November 1, 2024. The BELTSS website did not identify HM-C as the DOR for licensee.<br><br>A review completed on the BELTSS website indicated HM-C did have an ALD license issued July 7, 2021, with an expiration of October 31, 2025. HM-C was not listed as the LALD for the licensee on the BELTSS website.<br><br>HM-C also stated she was offered the position of LALD for the licensee on November 1, 2024, but had not made the decision at the time of the entrance conference if she would accept the position.<br><br>The licensee's 4.01 Assisted Living Director policy dated June 12, 2024, indicated licensee would have a LALD but the policy lacked indication the LALD would be identified as the DOR on the BELTSS website.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Two (2) days | 0 110 | | |
| 0 450 SS=C | 144G.41 Subdivision 1 Minimum requirements<br><br>All assisted living facilities shall:<br>(1) distribute to residents the assisted living bill of rights;<br>(2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285;<br>(3) utilize a person-centered planning and service delivery process;<br>(4) have and maintain a system for delegation of | 0 450 | | |

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| 0 450 | Continued From page 3<br><br>health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285;<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to provide the current assisted living bill of rights (BOR) to two of two residents (R1, R2).<br><br>This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) 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 the residents).<br><br>The findings include:<br><br>R1 admitted on May 6, 2020.<br><br>R1's record lacked a copy of the assisted living BOR.<br><br>R2 was admitted on December 5, 2021.<br><br>R2's record lacked a copy of the assisted living BOR.<br><br>On November 4, 2024, at approximately 11:00 a.m., house manager (HM)-C acknowledged the BOR was not provided and stated the licensee would need to provide and document receipt of current assisted living BOR to all residents. | 0 450 | | |

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| 0 450 | Continued From page 4<br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 450 | | |
| 0 470 SS=F | 144G.41 Subdivision 1 Minimum requirements<br><br>(11) develop and implement a staffing plan for determining its staffing level that:<br>(i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility;<br>(ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and<br>(iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility;<br>(12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be:<br>(i) awake;<br>(ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time;<br>(iii) capable of communicating with residents;<br>(iv) capable of providing or summoning the appropriate assistance; and<br>(v) capable of following directions;<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record | 0 470 | | |

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| 0 470 | Continued From page 5<br><br>review, the licensee failed to ensure a staffing plan was developed, potentially affecting all licensee's current residents, staff, and visitors.<br><br>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).<br><br>The findings include:<br><br>During facility tour on November 4, 2024, at 11:30 a.m., the surveyor observed a posted staff schedule indicating which staff member was working on each shift.<br><br>During interview on November 4, 2024, at 1:00 p.m., the surveyor asked clinical nurse supervisor (CNS)-A who the registered nurse (RN) was for the licensee. CNS-A stated she was the only RN for the licensee at the time. The surveyor then asked CNS-A if she or another RN had developed a staffing plan. CNS-A stated she knew that administration made the schedules for staff. CNS-A denied developing a staffing plan and indicated she was not aware she needed to develop a staffing plan.<br><br>The licensee's July 1, 2024, Staffing Plan policy did not indicate who was responsible for developing the licensee's staffing plan. The policy stated the CNS was required to develop and post a 24-hour daily staffing schedule.<br><br>No further information was provided. | 0 470 | | |

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| 0 470 | Continued From page 6<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 470 | | |
| 0 480 SS=F | 144G.41 Subd 1 (13) (i) (B) Minimum requirements<br><br>(13) offer to provide or make available at least the following services to residents:<br>(B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code.<br><br>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).<br><br>The findings include:<br><br>Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated November 5, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. | 0 480 | | |

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| 0 480 | Continued From page 7<br>TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates. | 0 480 | | |
| 0 510 SS=F | 144G.41 Subd. 3 Infection control program<br><br>(a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control.<br>(b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities.<br>(c) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to ensure infection control standards were followed for one of one unlicensed personnel (ULP))-E) providing food preparation for resident meals. This had the potential to affect all residents.<br><br>This practice resulted in a level two violation (a violation that did not harm a client'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).<br><br>The findings include: | 0 510 | | |

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| 0 510 | Continued From page 8<br><br>During a tour of licensee's facility on November 4, 2024, at 12:05 p.m., ULP-E was in the kitchen of House 2 and was speaking with a resident when the surveyor arrived. ULP-E stated they were in the process of preparing lunch for the licensee's residents in House 2. ULP-E had removed a package of frozen hamburger from the kitchen freezer using ungloved hands. ULP-E applied gloves to both hands without washing hands with soap and water or sanitizing hands with hand sanitizer before applying gloves. ULP-E then proceeded to open a cabinet door while wearing gloves. ULP-E obtained a saucepan from the cupboard, closed the cupboard door, placed the saucepan on the kitchen stove, and obtained the plastic bag of frozen hamburger from the counter where it was placed. ULP-E removed the hamburger using the gloves that had been previously applied and placed the hamburger from the package into their left hand. ULP-E then placed the frozen hamburger into the saucepan and disposed of the plastic bag that held the frozen hamburger into the garbage container. ULP-E began to prepare the frozen hamburger using the same gloves they had originally applied to both hands. During this time, ULP-E conversed with the resident that was in the kitchen with ULP-E.<br><br>During interview on November 4, 2024, at 1:50 p.m., clinical nurse supervisor (CNS)-A stated all staff are educated on hand washing and glove use during orientation and annually. CNS-A stated ULP-E would need to be re-educated.<br><br>The licensee's infection control policy was requested but not received.<br><br>No further information provided. | 0 510 | | |

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| 0 510 | Continued From page 9<br><br>TIME PERIOD FOR CORRECTION: Two (2) Days | 0 510 | | |
| 0 550 SS=F | 144G.41 Subd. 7 Resident grievances; reporting maltreatment<br><br>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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure. This had the potential to affect all the licensee's current residents, staff, and visitors.<br><br>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 | 0 550 | | |

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| 0 550 | Continued From page 10<br><br>problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>On November 4, 2024, at approximately 11:30 a.m., during a facility tour, the surveyor did not observe a posting of the required grievance procedure content in a conspicuous place.<br><br>On November 4, 2024, at approximately 12:05 p.m., house manager (HM)-C confirmed the required grievance procedure content had not been posted but explained to surveyor they did provide the information on the licensee's grievance policy to each resident when they were admitted.<br><br>The licensee's Complaint Policy and Procedure dated January 9, 2024, did not indicate the information would be posted in an area accessible to residents, visitors, and employees.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 550 | | |
| 0 640 SS=F | 144G.42 Subd. 7 Posting information for reporting suspected c<br><br>The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by:<br>(1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; | 0 640 | | |

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|---|---|---|---|
| | 32608 | A. BUILDING: _____ B. WING _____ | 11/08/2024 |

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| 0 640 | Continued From page 11<br><br>(2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and<br>(3) providing reasonable accommodations with information and notices in plain language.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) and failed to post the 911 emergency number in common areas and near telephones in the licensee's dementia care area of the assisted living facility.<br><br>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).<br><br>The findings include:<br><br>During a facility tour on November 4, 2024, at 11:30 a.m., the surveyor noted the licensee's common areas had no posting of the 911 emergency number, or information related to reporting suspected maltreatment to MAARC.<br><br>During an interview on November 4, 2024, at 11:55 a.m., house manager (HM)-C stated she was not aware there had been no posting of 911 emergency number or information related to | 0 640 | | |

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| 0 640 | Continued From page 12<br>reporting suspected maltreatment to MAARC.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 640 | | |
| 0 660 SS=F | 144G.42 Subd. 9 Tuberculosis prevention and control<br><br>(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.<br>(b) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>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 a facility TB risk assessment.<br><br>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 | 0 660 | | |

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| 0 660 | Continued From page 13<br><br>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).<br><br>The findings include:<br><br>During the entrance conference on November 4, 2024, at 10:30 a.m., with clinical nurse supervisor (CNS)-A, house manager (HM)-C, and director of operations (DOA)-F, a request was made to review the facility TB risk assessment. HM-C stated the licensee had not completed a facility TB risk assessment.<br><br>The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include a facility TB risk assessment.<br><br>The licensee's TB Prevention and Control policy dated February 1, 2024, indicated the registered nurse (RN) would be responsible for conducting and reviewing the TB Prevention Plan and Risk Assessment.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 660 | | |
| 0 700 SS=F | 144G.43 Subdivision 1 Resident record<br><br>(b) Resident records, whether written or electronic, must be protected against loss, | 0 700 | | |

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| 0 700 | Continued From page 14<br><br>tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to maintain resident records with the required content for two of two residents ((R1, R2).<br><br>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 the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>R1 was admitted to the licensee on May 6, 2020.<br><br>R1's diagnoses included diffuse traumatic brain injury.<br><br>R1's record lacked a written and signed assisted living (AL) contract.<br><br>R2 was admitted to the licensee on December 5, 2021.<br><br>R2's diagnoses included Duchenne muscular dystrophy. | 0 700 | | |

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|---|---|---|---|---|
| 0 700 | Continued From page 15<br><br>R2's record lacked a written and signed AL contract.<br><br>During the entrance conference on November 4, 2024, at 10:30 a.m., house manager (HM)-C stated the licensee complied with the Minnesota (MN) assisted living laws and regulations.<br><br>During an interview on November 4,2024, at 12:45 p.m., HM-C stated the licensee did have signed AL contracts for R1 or R2. Director of operations (DOO)-F stated he would locate the contracts and bring for R1, R2, and R3.<br><br>DOO-F brought to surveyor R3's written contract on November 4, 2024, at 1:45 p.m.<br><br>During interview on November 4, 2024, at 1:50 p.m., DOO-F stated the contracts for R1 and R2 had not been found and was not aware where the contracts would have gone but believed they had been completed.<br><br>No further information was provided.<br><br>TIME PERIOD TO CORRECT: Seven (7) days | 0 700 | | |
| 0 780 SS=F | 144G.45 Subd. 2 (a) (1) Fire protection and physical environment<br><br>(a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:<br><br>(1) for dwellings or sleeping units, as defined in the State Fire Code:<br>(i) provide smoke alarms in each room used for sleeping purposes; | 0 780 | | |

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|---|---|---|---|---|
| 0 780 | Continued From page 16<br><br>(ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms;<br>(iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics;<br>(iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and<br>(v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to provide smoke alarms that functioned and were interconnected so that the actuation of one alarm caused all alarms in the dwelling unit to actuate and failed to comply with the current provision of the State Fire Code in Minnesota Rules, chapter 7511. These deficient conditions had the ability to affect all staff and residents.<br><br>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).<br><br>The findings include: | 0 780 | | |

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| 0 780 | Continued From page 17<br><br>On November 4, 2024, from 11:20 a.m. to 1:30 p.m., the surveyor toured the facility with maintenance director (MD)-D. The following was observed:<br><br>SMOKE ALARMS:<br>House 1<br>- Smoke alarm was not installed inside bedroom 101<br>- Smoke alarms were not installed in the hallways on the main level<br>- Smoke alarms were not installed in the hallways on the upper level<br>- Smoke alarms throughout the facility were not interconnected<br><br>House 2<br>- Smoke alarm was not installed inside or outside bedroom 101<br>- Smoke alarm was not installed inside bedroom 102<br>- Smoke alarm was not installed inside bedroom 205<br>- Smoke alarm was not installed inside bedroom 208<br><br>House 3<br>- Smoke alarm was not installed outside bedroom 101<br><br>EXIT DOOR OPERATION<br>House 1<br>- The closer was removed from the fire-rated exit door to the stairwell enclosure in the middle of the house and the door did not close and latch on its own.<br><br>House 2<br>- The fire-rated door to the exit stairwell by | 0 780 | | |

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|---|---|---|---|---|
| 0 780 | Continued From page 18<br><br>sleeping room 104 on the main level did not close and latch on its own.<br><br>House 3<br>- The closer was removed from the basement fire-rated door to the stairwell enclosure on the end of the house and the door did not close and latch on its own.<br>- The fire-rated exit door in the stairwell by sleeping room 104 did not close and latch on its own.<br>- The fire-rated door to the exit stairwell by sleeping room 104 did not close and latch on its own.<br><br>Fire-rated doors to exit stairwells must close and positively latch to maintain the fire resistance integrity of the assembly as designed.<br><br>On November 4, 2024, at 1:45 p.m. MD-D stated they did not realize the doors in the houses were not functioning correctly and stated they would get them fixed.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days. | 0 780 | | |
| 0 800 SS=F | 144G.45 Subd. 2 (a) (4) Fire protection and physical environment<br><br>(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. | 0 800 | | |

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| 0 800 | Continued From page 19<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to maintain 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. This deficient condition had the potential to affect all staff, residents, and visitors.<br><br>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).<br><br>The findings include:<br><br>On November 4, 2024, from 11:20 a.m. to 1:30 p.m., the surveyor toured the facility with maintenance director (MD)-D. The following was observed.<br><br>HOUSE 1<br>- The fan in the bathroom by bedroom 101 was missing the cover.<br>- There was significant water damage to the bathroom ceiling adjacent to bedroom 206 and 207.<br>- There was significant water damage to the ceiling in the basement. Multiple areas in the basement had the ceiling pulled down where it had been damaged.<br>- The carpet was pulled off the stairs going from the basement to the ground level landing. | 0 800 | | |

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|---|---|---|---|---|
| 0 800 | Continued From page 20<br><br>HOUSE 2<br>- There was a large hole cut into the fire-rated gypsum board on the underside of the stairwell in the basement.<br>- The wood deck had multiple locations where the wood was rotten or missing. MD-D had identified the locations with spray paint.<br>- Bedroom 103 had significant damage to the floor in the middle of the room. Pieces of the plank flooring were loose and other pieces were broken or missing.<br>- The handrail in the stairwell was not secured to the wall at the top of the stairs.<br><br>HOUSE 3<br>- Bedroom 103 had significant damage to the floor in the middle of the room. Pieces of the plank flooring were loose and gapping at the joints.<br>- The threshold of the exit door adjacent to bedroom 104 was loose and heavily weathered. The wood was splitting and splintering.<br><br>On November 4, 2024 at 1:45 p.m., MD-D stated they had recently return from a leave of absense and was struggling to catch up on the above listed maintenance items.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days. | 0 800 | | |
| 0 810 SS=F | 144G.45 Subd. 2 (b)-(f) Fire protection and physical environment<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping | 0 810 | | |

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|---|---|---|---|---|
| 0 810 | Continued From page 21<br>rooms;<br>(2) employee actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for residents; and<br>(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.<br>(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.<br>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.<br>(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.<br>(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 drill.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors.<br><br>This practice resulted in a level two violation (a | 0 810 | | |

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| 0 810 | Continued From page 22<br><br>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 potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>On November 4, 2024, at 1:30 p.m., the surveyor observed the fire safety and evacuation plan (FSEP) was not located in a central location for all staff accessibility. House Manager (HM)-C stated they were working on developing their FSEP and they did not have a copy of it onsite.<br><br>On November 4, 2024, at 1:39 p.m. the survey emailed HM-C requesting documentation for the FSEP, training records for staff and residents, and evacuation drill logs.<br><br>On November 4, 2024, at 3:09 p.m. the surveyor received an email from the provider with the following attachments:<br>"9.12 - Delegated Procedures - Competencies - Emergency and Disaster Preparedness",<br>"EP - Volunteers in an Emergency",<br>"EP - Building-Alternate Source of Energy",<br>"EP - Communication Plan",<br>"EP - Emergency - Evacuation Report",<br>"EP - Evacuation Plan"<br>"EP - Missing Resident Plan"<br>"EP - Shelter in Place Plan"<br>"EP - System of Medical Documentation"<br><br>FIRE SAFETY AND EVACUATION PLAN:<br>The licensee's FSEP, titled "9.12 - Delegated Procedures - Competencies - Emergency and Disaster Preparedness", dated October 3, 2024, | 0 810 | | |

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|---|---|---|---|---|
| 0 810 | Continued From page 23<br>failed to include the following:<br><br>The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine and Extinguish or Evacuate) but failed to include procedures for how staff are to complete each step.<br><br>The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency.<br><br>The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan, titled "EP - Emergency - Evacuation Report", dated November 4, 2024, included the identification of the evacuation assistance level of each resident, but did not include any procedures for staff on how to assist residents during evacuation nor did it include instructions for staff to follow in case of relocation.<br><br>TRAINING:<br>The licensee failed to provide evacuation training to residents at least once per year. HM-C lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan.<br><br>The licensee failed to provide training to | 0 810 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 32608 | A. BUILDING: _____ B. WING _____ | 11/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIONEER ESTATES | 8761 PRESERVE BOULEVARD EDEN PRAIRIE, MN 55344 |

| (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 24<br><br>employees on the FSEP upon hire and at least twice per year. HM-C lacked documentation showing any training was completed or training was scheduled for a future date for staff on the fire safety and evacuation plan.<br><br>On November 4, 2024, at 1:30 p.m., HM-C stated they understood the requirements for training residents and staff and would implement a training program that was compliant with statute requirements once they finished developing their FSEP. HM-C stated they were recently asked to take on a leadership role at the facility and didn't have anything set up yet.<br><br>DRILLS:<br>The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. HM-C lacked documentation showing any evacuation drills were completed scheduled for a future date.<br><br>On November 4, 2024, at 1:30 p.m., HM-C stated there were no documented drills for the facility.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 0 810 | | |
| 01880 SS=F | 144G.71 Subd. 19 Storage of medications<br><br>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.<br><br>This MN Requirement is not met as evidenced by: | 01880 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 32608 | A. BUILDING: _____ B. WING _____ | 11/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIONEER ESTATES | 8761 PRESERVE BOULEVARD EDEN PRAIRIE, MN 55344 |

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|---|---|---|---|---|
| 01880 | Continued From page 25<br><br>Based on observation, interview, and record review, the facility failed to store all prescription medications according to the manufacturer's directions.<br><br>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).<br><br>The findings include:<br><br>During interview on November 4, 2024, at 10:50 a.m., clinical nurse supervisor (CNS)-A stated the licensee had a medication refrigerator located in locked closet of the kitchen in the home considered House 3 of the licensee's establishment.<br><br>During a tour of the licensee's establishment on November 4, 2024, at approximately 12:10 p.m., unlicensed personnel (ULP)-B was asked to indicate where the licensee's medication refrigerator was located. ULP-B escorted the surveyor to the medication closet where there was a dorm size refrigerator and separate dorm size freezer. Inside the refrigerator were two unopened packages of Admelog insulin pens. The surveyor also observed two unopened packages of Shingrix vaccine. The medication refrigerator was noted to not have at thermometer placed inside of the refrigerator or the freezer. There was no electronic thermometer attached to the medication refrigerator. ULP-B stated she was not aware there was a need to check the | 01880 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 32608 | A. BUILDING: _____ B. WING _____ | 11/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| PIONEER ESTATES | 8761 PRESERVE BOULEVARD EDEN PRAIRIE, MN 55344 |

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|---|---|---|---|---|
| 01880 | Continued From page 26<br><br>temperature of the medication refrigerator.<br><br>During interview on November 4, 2024, at 1:25 p.m., CNS-A stated the medications and vaccine in the refrigerator were used for resident administration and the refrigerator was to have a thermometer inside of it . CNS-A stated the staff were to record the temperatures of the medication refrigerator at least daily. CNS-A also stated she was not aware there was not a thermometer in the medication refrigerator and stated she would ensure this was addressed immediately.<br><br>Admelog insulin pen prescribing information dated August 2023, indicated the unused insulin pens should be stored in a refrigerator between 36 degrees Fahrenheit (°F) and 46°F (2 degrees Celsius (°C) and 8°C) until the expiration date.<br><br>Shringrix vaccine vials prescribing information dated May 2023, indicated to refrigerate both vials between 2°C and 8°C (36°F to 46°F). Protect vials from light. Discard if frozen. After reconstitution: administer immediately or store refrigerated between 2°C and 8°C (36°F to 46°F) for up to 6 hours.<br><br>The licensee's Storage of Medications policy dated August 1, 2022, indicated a registered nurse (RN) will recommend where medications should be stored along with manufacturer's recommendations.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01880 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 32608 | A. BUILDING: _____ B. WING _____ | 11/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| PIONEER ESTATES | 8761 PRESERVE BOULEVARD EDEN PRAIRIE, MN 55344 |

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|---|---|---|---|---|
| 01910 | Continued From page 27 | 01910 | | |
| 01910 SS=D | 144G.71 Subd. 22 Disposition of medications<br><br>(a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal.<br>(b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances.<br>(c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include the medication strength, prescription number, quantity, date of disposition, and names of staff and other individuals involved in the disposition for one of one discharged resident (R4).<br><br>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 | 01910 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 32608 | A. BUILDING: _____ B. WING _____ | 11/08/2024 |

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|---|---|---|---|---|
| 01910 | Continued From page 28<br><br>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).<br><br>The findings include:<br><br>R4 was discharged from the licensee on September 6, 2024.<br><br>R4's Service Plan dated July 17, 2024, indicated R4 received services to include medication management, assistance with activities of daily living, staff supervision, food preparation, and monitoring and reassessment.<br><br>R4's record lacked documentation of the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition.<br><br>On November 4, 2024, at 1:25 p.m., clinical nurse supervisor (CNS)-A stated she believed there had been a record indicating the licensee completed medication disposition after R4 discharged. CNS-A acknowledged R4's record was missing the required content above and stated the licensee would look for and provide to surveyor the record documenting the disposition of R4's medications at the time of discharge.<br><br>The licensee's Drug Disposition policy dated September 30, 2020, indicated staff will document in the resident's record the name of the person to whom the medications were given, the time and date, the name of each medication and the amount of medication remaining. | 01910 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| 01910 | Continued From page 29<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01910 | | |

Minnesota Department of Health

625 Robert Street North
St Paul
651-201-4500

Type: Full
Date: *11/05/24*
Time: 10:53:27
Report: 7994241204

# Food and Beverage Establishment Inspection Report



**Location:**

Pioneer Estates
8761 Preserve Boulevard
Eden Prairie, MN55344
Hennepin County, 27

**Establishment Info:**

ID #: 0037728
Risk:
Announced Inspection: No

**License Categories:**

Expires on: / /

**Operator:**

Phone #: 6122000901
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.

**3-300A Protection from Contamination: limit hand contact, tasting**

***3-301.11A*** ***** Priority 1 *****

MN Rule 4626.0225A Discontinue bare hand contact with ready-to-eat foods. Use deli tissue, spatulas, tongs, single-use gloves or other dispensing equipment.

BARE HAND CONTACT OBSERVED WHEN MAKING PLATES FOR RESIDENTS IN ONE KITCHEN. ENSURE GLOVES OR OTHER EFFECTIVE MEANS ARE USED WHEN PLATING FOODS.

*Comply By: 11/05/24*

**3-300B Protection from Contamination: cross-contamination, eggs**

***3-302.11A(1)*** ***** Priority 1 *****

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

EGGS FOUND STORED IN THE MIDDLE OF THE FRIDGE. MOVE THESE TO THE LOWEST POSSIBLE SHELF.

*Comply By: 11/05/24*

**4-300 Equipment Numbers and Capacities**

***4-302.13A*** ***** Priority 2 *****

MN Rule 4626.0710A Provide a readily accessible temperature measuring device for measuring the washing and sanitizing temperatures in manual warewashing operations.

NO METHOD OF TESTING THE DISHWASHER TEMP WAS FOUND ON SITE. LEFT TEST STRIPS AND THE FACILITY WILL EMAIL PICTURES OF THE TEST STRIPS LATER TODAY/TOMRROW.

*Comply By: 11/05/24*

**6-300 Physical Facility Numbers and Capacities**

***6-301.12*** ***** Priority 2 *****

MN Rule 4626.1445 Provide and maintain a supply of individual disposable towels, a continuous towel system, a heated-air hand drying device, or an approved ambient air temperature hand drying device at each handwashing sink or group of adjacent handwashing sinks.

HANDWASH SINK FOUND WITHOUT STOCKED PAPER TOWELS. ENSURE THEY ARE STOCKED WHEN THE DISPENSER RUNS OUT.

*Comply By: 11/05/24*

**2-100 Supervision**

***2-102.12AMN***

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

NO CURRENT CFPM CERTIFICATE WAS FOUND ON SITE.

*Comply By: 11/05/24*

**2-300 Personal Cleanliness**

***2-303.11***

MN Rule 4626.0095 Food employees must not wear jewelry on their arms and hands while preparing food with the exception of a plain ring with a flat, smooth band.

STAFF OBSERVED WITH A NUMBER OF RINGS IN PLACE DURING FOOD PREP. ENSURE THESE ARE REMOVED DURING FOOD PREP.

*Comply By: 11/05/24*

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

INSPECTION CONDUCTED AFTER COMMUNICATING WITH HRD STAFF AND FINDINGS SHARED AT THE END OF INSPECTION.

WILL EMAIL SUPPORTING DOCUMENTS AND LINKS TO HRD STAFF AT THE END OF THE DAY.

KITCHEN IS RESIDENTIAL AND FOOD IS PREPARED FOR SAME DAY SERVICE.

FLOOR IS CERAMIC TILE, CABINETS ARE WOOD , GRANITE COUNTER TOPS AND SMOOTH PAINTED CEILING. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT ANY TIME THERE IS FOUND TO BE A RISK OF CONTAMINATION OR CONCERN THE PHYSICAL FACILITIES WILL BE REQUIRED TO BE BROUGHT UP TO CODE.

TEMPERATURES
MILK 40
VEG 40
SLICED MEATS 39

Type: Full
Date: *11/05/24*
Time: 10:53:27
Report: 7994241204
Pioneer Estates

# 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 7994241204 of 11/05/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Signed:_____
Establishment Representative

Signed: Crystal Elva
Crystal Elva
Public Health Sanitarian 3
St Paul
651-201-3981
Crystal.Elva@state.mn.us

Report #: 7994241204

# Food Establishment Inspection Report

Minnesota Department of Health

625 Robert Street North
St Paul

| | |
|---|---|
| No. of RF/PHI Categories Out | 4 |
| No. of Repeat RF/PHI Categories Out | 0 |
| Legal Authority MN Rules Chapter 4626 | |

Date 11/05/24
Time In 10:53:27
Time Out

| | Address | City/State | Zip Code | Telephone |
|---|---|---|---|---|
| Pioneer Estates | 8761 Preserve Boulevard | Eden Prairie, MN | 55344 | 6122000901 |

| License/Permit # | Permit Holder | Purpose of Inspection | Est Type | Risk Category |
|---|---|---|---|---|
| 0037728 | | Full | | |

## FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

**IN=** in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

| Compliance Status | | | COS | R |
|---|---|---|---|---|
| **Supervision** | | | | |
| 1 | IN OUT | PIC knowledgeable; duties & oversight | | |
| 2 | IN OUT N/A | Certified food protection manager, duties | | |
| **Employee Health** | | | | |
| 3 | IN OUT | Mgmt/Staff;knowledge,responsibilities&reporting | | |
| 4 | IN OUT | Proper use of reporting, restriction & exclusion | | |
| 5 | IN OUT | Procedures for responding to vomiting & diarrheal events | | |
| **Good Hygenic Practices** | | | | |
| 6 | IN OUT N/O | Proper eating, tasting, drinking, or tobacco use | | |
| 7 | IN OUT N/O | No discharge from eyes, nose, & mouth | | |
| **Preventing Contamination by Hands** | | | | |
| 8 | IN OUT N/O | Hands clean & properly washed | | |
| 9 | IN OUT N/A N/O | No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed | | |
| 10 | IN OUT | Adequate handwashing sinks supplied/accessible | | |
| **Approved Source** | | | | |
| 11 | IN OUT | Food obtained from approved source | | |
| 12 | IN OUT N/A N/O | Food received at proper temperature | | |
| 13 | IN OUT | Food in good condition, safe, & unadulterated | | |
| 14 | IN OUT N/A N/O | Required records available; shellstock tags, parasite destruction | | |
| **Protection from Contamination** | | | | |
| 15 | IN OUT N/A N/O | Food separated and protected | | |
| 16 | IN OUT N/A | Food contact surfaces: cleaned & sanitized | | |
| 17 | IN OUT | Proper disposition of returned, previously served, reconditioned, & unsafe food | | |

| Compliance Status | | | COS | R |
|---|---|---|---|---|
| **Time/Temperature Control for Safety** | | | | |
| 18 | IN OUT N/A N/O | Proper cooking time & temperature | | |
| 19 | IN OUT N/A N/O | Proper reheating procedures for hot holding | | |
| 20 | IN OUT N/A N/O | Proper cooling time & temperature | | |
| 21 | IN OUT N/A N/O | Proper hot holding temperatures | | |
| 22 | IN OUT N/A | Proper cold holding temperatures | | |
| 23 | IN OUT N/A N/O | Proper date marking & disposition | | |
| 24 | IN OUT N/A N/O | Time as a public health control: procedures & records | | |
| **Consumer Advisory** | | | | |
| 25 | IN OUT N/A | Consumer advisory provided for raw/undercooked food | | |
| **Highly Susceptible Populations** | | | | |
| 26 | IN OUT N/A | Pasteurized foods used; prohibited foods not offered | | |
| **Food and Color Additives and Toxic Substances** | | | | |
| 27 | IN OUT N/A | Food additives: approved & properly used | | |
| 28 | IN OUT | Toxic substances properly identified, stored, & used | | |
| **Conformance with Approved Procedures** | | | | |
| 29 | IN OUT N/A | Compliance with variance/specialized process/HACCP | | |

**Risk factors** (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

## GOOD RETAIL PRACTICES

**Good Retail Practices** are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

| | | | COS | R |
|---|---|---|---|---|
| **Safe Food and Water** | | | | |
| 30 | IN OUT N/A | Pasteurized eggs used where required | | |
| 31 | | Water & ice obtained from an approved source | | |
| 32 | IN OUT N/A | Variance obtained for specialized processing methods | | |
| **Food Temperature Control** | | | | |
| 33 | | Proper cooling methods used; adequate equipment for temperature control | | |
| 34 | IN OUT N/A N/O | Plant food properly cooked for hot holding | | |
| 35 | IN OUT N/A N/O | Approved thawing methods used | | |
| 36 | | Thermometers provided & accurate | | |
| **Food Identification** | | | | |
| 37 | | Food properly labled; original container | | |
| **Prevention of Food Contamination** | | | | |
| 38 | | Insects, rodents, & animals not present | | |
| 39 | | Contamination prevented during food prep, storage & display | | |
| 40 | X | Personal cleanliness | | |
| 41 | | Wiping cloths: properly used & stored | | |
| 42 | | Washing fruits & vegetables | | |

| | | | COS | R |
|---|---|---|---|---|
| **Proper Use of Utensils** | | | | |
| 43 | | In-use utensils: properly stored | | |
| 44 | | Utensils, equipment & linens: properly stored, dried, & handled | | |
| 45 | | Single-use/single service articles: properly stored & used | | |
| 46 | | Gloves used properly | | |
| **Utensil Equipment and Vending** | | | | |
| 47 | | Food & non-food contact surfaces cleanable, properly designed, constructed, & used | | |
| 48 | X | Warewashing facilities: installed, maintained, & used; test strips | | |
| 49 | | Non-food contact surfaces clean | | |
| **Physical Facilities** | | | | |
| 50 | | Hot & cold water available; adequate pressure | | |
| 51 | | Plumbing installed; proper backflow devices | | |
| 52 | | Sewage & waste water properly disposed | | |
| 53 | | Toilet facilities: properly constructed, supplied, & cleaned | | |
| 54 | | Garbage & refuse properly disposed; facilities maintained | | |
| 55 | | Physical facilities installed, maintained, & clean | | |
| 56 | | Adequate ventilation & lighting; designated areas used | | |
| 57 | | Compliance with MCIAA | | |
| 58 | | Compliance with licensing & plan review | | |

**Food Recalls:**

**Person in Charge (Signature)** **Date:** 11/05/24

Inspector (Signature) Crystal Elva