Electronically Delivered

July 25, 2023

Licensee
Brookdale Eagan
1365 Crestridge Lane
Eagan, MN 55123

RE: Project Number(s) SL30683015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 9, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

The correction order documentation should include the following:

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

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

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

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

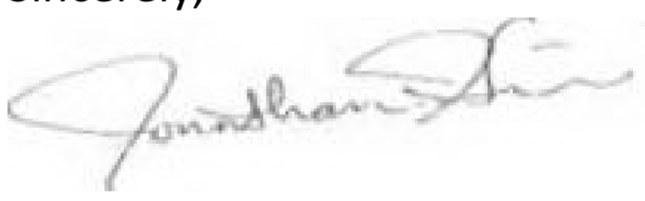
Please address your cover letter for reconsideration requests to:

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

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,



Jonathan Hill, Supervisor
State Evaluation Team
Email: jonathan.hill@state.mn.us
Telephone: 651-201-3993 Fax: 651-281-9796

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30683	A. BUILDING: _____ B. WING _____	06/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAGAN	1365 CRESTRIDGE LANE EAGAN, MN 55123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30683015-0 On June 5 through June 9, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 31 active residents receiving services under the Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30683	A. BUILDING: _____ B. WING _____	06/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAGAN	1365 CRESTRIDGE LANE EAGAN, MN 55123

(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
0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This had the potential to affect all residents of the assisted living facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report, dated June 6, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=E	144G.41 Subd. 3 Infection control program (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. (b)The facility's infection control program must be	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30683	A. BUILDING: _____ B. WING _____	06/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAGAN	1365 CRESTRIDGE LANE EAGAN, MN 55123

(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
0 510	Continued From page 2 consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control. The licensee failed to ensure proper cleaning of shared assistive devices after use, between residents. Further the licensee failed to ensure direct care staff performed adequate hand hygiene (HH) for 1 of 3 observed staff (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-C was hired October 7, 2019, and provided direct care services for residents. On June 6, 2023, during a continuous observation from 7:35 a.m to 8:31 a.m., ULP-C provided direct cares for residents.	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30683	A. BUILDING: _____ B. WING _____	06/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAGAN	1365 CRESTRIDGE LANE EAGAN, MN 55123

(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
0 510	Continued From page 3 -at 7:35 a.m., ULP-C performed HH, knocked, and entered R3's room with ULP-D. Both ULPs donned gloves and assisted R3 with morning activities of daily living (ADLs) including incontinent care, dressing, and transfer from the bed to broda chair (a reclining wheelchair). ULP-C removed gloves, then donned a clean pair of gloves, combed R3's hair, removed gloves, and performed HH by applying soap and rubbing hands together under running water for 12 seconds. ULP-C pulled the trash bag out, set it on the floor and put a clean bag into the trash can, and further straightened the room, while ULP-D assisted R3 with oral care. ULP-C opened the window blinds, picked up the trash, exited R3's room, and took the trash bag to the trash room. -at 8:03 a.m., ULP-C performed HH by applying soap and rubbing hands together under running water for 12 seconds. -at 8:05 a.m., ULP-C responded to a call light, entering R5's room. ULP-C donned gloves, gathered clothing and assisted R5 to the bathroom. ULP-C assisted R5 to stand, lowered soiled brief and assisted R5 to sit on the toilet. ULP-C removed the soiled brief, placed a clean brief and pants to R5's legs, and assisted R5 to put on a clean shirt. ULP-C, without removing soiled gloves, got a towel out of R5's closet, then washed R5's face with a wet washcloth. ULP-C dried R5's face with the towel, combed R5's hair, then assisted R5 to stand up from the toilet. ULP-C performed perineal care using cleansing wipes, pulled up the clean brief and pants, and assisted R5 to sit in the wheelchair. Without removing soiled gloves, ULP-C retrieved R5's toothbrush, added toothpaste, and assisted R5 to brush teeth. Without removing soiled gloves, ULP-C wiped toothpaste from the corner of R5's mouth using her thumb, then flushed the toilet, straightened R5's room, emptied the bathroom	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30683	A. BUILDING: _____ B. WING _____	06/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAGAN	1365 CRESTRIDGE LANE EAGAN, MN 55123

(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
0 510	Continued From page 4 trash, and placed a clean trash bag into the can. ULP-C then removed the soiled gloves, and, carrying the trash bag in her left hand, pushed R5, in her wheelchair, using both hands. ULP-C stopped at the trash room, opened the door and deposited the trash, then pushed R5, in her wheelchair, into the dining room. -at 8:20 a.m., ULP-C performed HH by applying soap, rubbed hands together for 10 seconds, then placed hands under running water and rubbed together under running water for an additional 6 seconds, and dried. ULP-C then served juice to R5. ULP-C donned gloves, prepared juice for R3 and R7, and provided spoons to R3, R7, and R8. ULP-C then retrieved clothing protectors and placed them on R3, R7, and R8. -at 8:31 a.m., ULP-C stated she would then assist R8 to eat breakfast. On June 6, 2023, at 8:31 a.m., ULP-C stated she had annual infection control training through an online training system, but had not had in-person training or testing. ULP-C was not aware of any observation of HH by registered nurse (RN)-B or licensed practical nurse (LPN)-E. ULP-C stated she was taught to wash hands before and after cares, with soap, for 20 seconds, but was usually rushed because they were very busy. ULP-C further stated they did not carry hand sanitizer and it was only available at the medication cart. ULP-C added it was too far to walk to the medication cart to use the hand sanitizer. On June 7, 2023, at 9:32 a.m., LPN-E stated HH training was completed online. LPN-E stated she often observed HH and did not have any official documentation, but would retrain on the spot if she saw deficient practice. LPN-E further stated HH is usually covered at monthly staff meetings.	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30683	A. BUILDING: _____ B. WING _____	06/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAGAN	1365 CRESTRIDGE LANE EAGAN, MN 55123

(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
0 510	Continued From page 5 LPN-E further stated all staff should perform HH with glove changes, between residents, when moving from a dirty area to clean, and when gloves were visibly soiled. LPN-E further stated sanitizer was not a good option around residents with dementia, and staff were expected to wash hands with soap and for 20 seconds. On June 7, 2023, at 2:28 p.m., clinical nurse supervisor (CNS)-B stated they had not done HH audits. CNS-B stated HH is part of the ULPs annual training and should be completed before donning and after doffing gloves, between cares, upon entering and exiting a resident room, and also when moving to a clean area after contact with a dirty area such as performing perineal cares. The CDC guidance, CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, revised November 29, 2022, indicated, standard precautions were to be used to care for all patients in all settings to include HH, and noted, "Use an alcohol-based hand rub or wash with soap and water for the following clinical indications: a. Immediately before touching a patient b. Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices c. Before moving from work on a soiled body site to a clean body site on the same patient d. After touching a patient or the patient's immediate environment e. After contact with blood, body fluids or contaminated surfaces f. Immediately after glove removal." The licensee's Handwashing/Hand Hygiene	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30683	A. BUILDING: _____ B. WING _____	06/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAGAN	1365 CRESTRIDGE LANE EAGAN, MN 55123

(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
0 510	Continued From page 6 policy, dated October 2021 , indicated hands should be washed with soap and water for at least 20 seconds. The policy further indicated, "CDC recommends using Alcohol Based Hand Sanitizer with 60-95% alcohol in healthcare settings. Unless hands are visibly soiled, an alcohol-based hand rub is preferred over soap and water in most clinical situations due to evidence of better compliance compared to soap and water during routine resident care. a) Before and after coming on duty; b) Before and after direct contact with residents; c) Before preparing or handling medications; d) Before performing any non-surgical invasive procedures; e) Before and after handling an invasive device (e.g., urinary catheters, IV access sites); f) Before donning sterile gloves; g) Before handling clean or soiled dressings, gauze pads, etc.; h) Before moving from a contaminated body site to a clean body site during resident care; i) After contact with a resident's intact skin; j) After contact with blood or bodily fluids; k) After handling used dressings, contaminated equipment, etc.; l) After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident; m) After removing gloves; n) Before and after entering isolation precaution settings; o) Before and after assisting a resident with meals;". The policy further indicated HH should be performed before applying and after removing gloves. No further information was provided.	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30683	A. BUILDING: _____ B. WING _____	06/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAGAN	1365 CRESTRIDGE LANE EAGAN, MN 55123

(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
0 510	Continued From page 7 TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse and prevention plan (IAPP) contained statements of the specific measures to be taken by staff to minimize the risk of abuse for 3 of 3 residents (R2, R3, R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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:	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30683	A. BUILDING: _____ B. WING _____	06/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAGAN	1365 CRESTRIDGE LANE EAGAN, MN 55123

(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
0 630	Continued From page 8 R2 R2 had diagnoses including Alzheimer's dementia, and obesity. R2's service plan, dated April 10, 2023, indicated R2 received services including assistance with medication management, catheter care, toileting, dressing and grooming, cognitive/psychosocial needs, behavior management, housekeeping, and laundry. R2's Vulnerability Assessment and IAPP, dated December 28, 2022, indicated R2 had vulnerabilities in the following areas: cognitive impairment, inability to independently maintain a safe and clean environment, visual or hearing deficits, making needs known, and difficulty reporting abuse and requiring assistance in emergency situations. R3 R3 had diagnoses including dementia and paraplegia (impairment of the lower extremities). R3's service plan, dated May 30, 2023, indicated R3 received services including assistance with medication management, dressing and grooming, toileting, transfers, cognitive/psychosocial needs, housekeeping, and laundry. R3's Vulnerability Assessment and IAPP, dated January 30, 2023, indicated R3 had vulnerabilities in the following areas: cognitive impairment, inability to independently maintain a safe and clean environment, visual or hearing deficits, making needs known, ability to manage finances, and difficulty reporting abuse and requiring assistance in emergency situations.	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30683	A. BUILDING: _____ B. WING _____	06/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAGAN	1365 CRESTRIDGE LANE EAGAN, MN 55123

(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
0 630	Continued From page 9 R6 R6 had diagnoses including Alzheimer's dementia and mood disorder. R6's service plan, dated March 27, 2023, indicated R6 received services including assistance with dressing and grooming, medication management, bathing, escort and mobility, housekeeping, and laundry. R6's Vulnerability Assessment and IAPP dated December 2, 2022, indicated R6 had vulnerabilities in the following areas: cognitive impairment, in ability to independently maintain a safe and clean environment, reluctance to accept support, and difficulty reporting abuse and requiring assistance in emergency situations. R2, R3, and R6's IAPPs lacked individualized interventions for the areas of vulnerability identified. The forms included spaces after each question to enter "specific measures to minimize risk to resident", which were left blank. On June 6, 2023, at 4:28 p.m., clinical nurse supervisor (CNS)-B stated she performed the vulnerability assessments and understood interventions would need to be added to complete the IAPP. The licensee's individual abuse prevention plan policy, revised August 2021, indicated, "Upon move in, each resident should have an Individual Abuse Prevention Plan completed. The vulnerability of each [licensee] resident will be addressed on the service plan for associates to have awareness of a resident's vulnerable area(s) with ways to individually manage these concerns to minimize the risk of abuse or neglect for the resident."	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30683	A. BUILDING: _____ B. WING _____	06/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAGAN	1365 CRESTRIDGE LANE EAGAN, MN 55123

(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
0 630	Continued From page 10 No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, 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 includes baseline testing, and training for one of three employees (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30683	A. BUILDING: _____ B. WING _____	06/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAGAN	1365 CRESTRIDGE LANE EAGAN, MN 55123

(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
0 660	Continued From page 11 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). Findings include: The facility TB risk assessment was completed May 8, 2023, and indicated the facility was at a low risk for TB transmission. ULP-C was hired October 7, 2019, and provided direct care services to the residents of the facility. On June 6, 2023, at 7:35 a.m., ULP-C was observed to assist R3 with activities of daily living (ADLs). ULP-C's employee record included a TB history and symptom screening form completed January 15, 2022, but lacked documentation of a baseline TB test completed upon hire. On June 6, 2023, at 10:58 a.m., licensed assisted living director (LALD)-A stated they had no TB screening info for ULP-C, but would check to see if it was on file at the corporate office. On June 6, 2023, at 12:17 p.m., ULP-C stated she was "pretty sure" she had a TB test for another job, but was not sure if she had completed any TB test when she began working for the licensee. On June 6, 2023, at 12:49 p.m., LALD-A stated the corporate office did not have TB testing information for ULP-C on file.	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30683	A. BUILDING: _____ B. WING _____	06/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAGAN	1365 CRESTRIDGE LANE EAGAN, MN 55123

(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
0 660	Continued From page 12 The Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, noted, "The purpose of this manual is to assist health care facilities in Minnesota to understand what is needed to be in compliance with Minnesota laws revised in 2013 regarding TB prevention and control, and to provide tools for implementing legal regulations and best practices in their settings." This included, Baseline TB screening is required for all health care workers (HCW). Baseline TB screening consists of three components: 1. Assessing for current symptoms of active TB disease; 2. Assessing TB history; 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single IGRA; and An employee may begin working with patients after a negative TB symptom screen (i.e., no symptoms of active TB disease) and a negative IGRA or TST (i.e., frst step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients." The licensee's Tuberculosis Exposure Control Plan policy revised September, 2021, indicated, "5. The TB status of the associate should be established prior to initial assignment and screened at least annually thereafter, or according to state regulations. 6. The initial screening should be completed using the one-step Mantoux skin test and a medical history. a. Thereafter, the one-step Mantoux skin test is completed annually or according to state	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30683	A. BUILDING: _____ B. WING _____	06/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAGAN	1365 CRESTRIDGE LANE EAGAN, MN 55123

(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
0 660	Continued From page 13 regulations. b. In the event state law or licensing agencies require more than the [licensee] standard, follow the state guidelines, which may include additional steps such as the QuantiFERON - TB Gold Test. c. See attached resource for state specific state laws." 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 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	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30683	A. BUILDING: _____ B. WING _____	06/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAGAN	1365 CRESTRIDGE LANE EAGAN, MN 55123

(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
0 680	Continued From page 14 working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to post an emergency preparedness plan prominently and to have a written emergency preparedness (EP) plan with all the required content. 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: On June 5, 2023, at 11:45 a.m., a request was made to view the licensee's emergency preparedness plan, which was later reviewed by the surveyor. -during the facility tour at 12:30 p.m., the surveyor observed the facility's layout to include the main entrance and a large common area. The facility lacked an emergency disaster plan posted prominently, as required. The licensee's EP plan lacked the following required content: -a process for emergency preparedness (EPS) cooperation with state and local EP officials/organizations -handling and use of volunteers	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30683	A. BUILDING: _____ B. WING _____	06/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAGAN	1365 CRESTRIDGE LANE EAGAN, MN 55123

(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
0 680	Continued From page 15 -a communication plan with the following required content: names and contact information for staff/entities providing services under an agreement, residents' physicians, other facilities, volunteers, federal, state, tribal, regional, and local emergency preparedness staff, state licensing and certification agency -EP testing requirements including an annual full-scale exercise or individual facility-based functional exercise as well as a secondary exercise. During an interview on June 6, 2023, at 1:00 p.m., licensed assisted living director (LALD)-A stated the facility had just joined an emergency preparedness coalition and recognized the emergency preparedness manual had not been developed to include all the required information. LALD-A further stated the emergency preparedness plan was kept available behind the front desk. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30683	A. BUILDING: _____ B. WING _____	06/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAGAN	1365 CRESTRIDGE LANE EAGAN, MN 55123

(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
0 730	Continued From page 16 providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30683	A. BUILDING: _____ B. WING _____	06/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAGAN	1365 CRESTRIDGE LANE EAGAN, MN 55123

(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
0 730	Continued From page 17 licensee failed to ensure the resident record included documentation of all provided services for two of three residents (R3, R6). 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 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: R3 R3 had diagnoses including dementia and paraplegia (impairment of the lower extremities). R3's service plan, dated May 30, 2023, indicated R3 received services including assistance with medication management, dressing and grooming, toileting, transfers, cognitive/psychosocial needs, housekeeping, and laundry. On a caregiver assignment sheet, dated June 5, 2023, a section titled "Details" indicated R3 was to be repositioned every 2 hours at night. R3's activities of daily living (ADL) record lacked documentation R3 received the following scheduled services, or documentation why the following services were not provided: June 1 through June 5, 2023, night shift: -wheelchair cleaning; -sleep checks every 2-4 hours; -catheter care; -continence care; and -laundry.	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30683	A. BUILDING: _____ B. WING _____	06/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAGAN	1365 CRESTRIDGE LANE EAGAN, MN 55123

(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
0 730	Continued From page 18 R6 R6 had diagnoses including Alzheimer's dementia and mood disorder. R6's service plan, dated March 27, 2023, indicated R6 received services including assistance with dressing and grooming, medication administration, showering or bathing (Tuesday and Friday p.m.), escort and mobility, housekeeping (daily), and laundry (on shower days). R6's ADL record lacked documentation R6 received the following scheduled services, or documentation why the following services were not provided: June 1 through June 3, 2023, p.m. shift: -dressing and grooming; -assistance with glasses; -assistance with cane; -removal of compression stockings; -showering (Fridays); -linen change on shower day; -laundry; -housekeeping; and -escort and mobility. June 1 though June 2, 2023, night shift: -sleep checks every 2-4 hours; and -laundry. At 3:50 p.m., during an interview, clinical nurse supervisor (CNS)-B stated she was aware of the missing documentation in the resident record. CNS-B further stated, "we have been encouraging staff to record cares, and letting them know it's a state requirement." The licensee's ADL Care Documentation Policy, dated September 2022, indicated, "Activities of	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30683	A. BUILDING: _____ B. WING _____	06/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAGAN	1365 CRESTRIDGE LANE EAGAN, MN 55123

(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
0 730	Continued From page 19 daily living care will be documented daily for residents per Minnesota state regulations." The policy further indicated, "1. Activities of Daily Living (ADL) includes assistance to the resident with eating, bathing, dressing ,grooming, toileting, personal laundry, housekeeping, escorting to programming, mobility, ambulating, continence care, night sleep checks, and verifying elimination patterns. 2. ADL care should be documented on the ADL Sheet on a daily basis for AM, PM, and Night shift care. 3. ADL care that is not performed during a shift should be reported to the manager on duty of that shift and to the incoming associates of the next shift. Care that is not performed whether because of resident declination or other circumstance should be documented in the resident's record along with the reason the ADL Care was not performed by the nurse/designee. 4. Repetitive refusal or declination of ADL Care should be reported to the Executive Director (ED), Health and Wellness Director (HWD), nurse or designee and then appropriately communicated to the resident's responsible party and/or physician/healthcare provider as necessary. 5. ADL Sheets are stored in the residents' record." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30683	A. BUILDING: _____ B. WING _____	06/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAGAN	1365 CRESTRIDGE LANE EAGAN, MN 55123

(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
0 800	Continued From page 20 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, visitors, 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) 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 June 8, 2023, approximately from 12:30 p.m. to 2:15 p.m., survey staff toured the facility with the maintenance manager (MM)-P. During the tour, survey staff observed the following: -The set of double-fired-rated doors (1.5 hours) for the furnace rooms located in building exit corridors A, E, and F did not latch when closed as required to protect the exit passageway to the exterior of the building. In addition, the hallway "E" furnace closet had missing latch hardware. -The sprinkler riser room wall had large	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30683	A. BUILDING: _____ B. WING _____	06/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAGAN	1365 CRESTRIDGE LANE EAGAN, MN 55123

(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
0 800	Continued From page 21 penetration (sheetrock broken) that was not sealed to maintain the fire-rated integrity of the room. The above findings were physically and/or verbally verified by the MM-P accompanying the facility tour. On June 8, 2023, at approximately 2:45 p.m., during the exit interview, the MM-P acknowledged the findings. 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	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30683	A. BUILDING: _____ B. WING _____	06/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAGAN	1365 CRESTRIDGE LANE EAGAN, MN 55123

(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 22 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 drill. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to provide the required employee and resident training on the fire safety and evacuation plan. This has the potential to directly affect the safety of all residents receiving 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 or has the potential to affect a large portion or all of the residents). The findings include: On June 8, 2023, at approximately 2:15 p.m., survey staff received the facility fire safety and evacuation plan and related documentation for review from the maintenance manager (MM)-P. At approximately 2:30 p.m., document review and	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30683	A. BUILDING: _____ B. WING _____	06/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAGAN	1365 CRESTRIDGE LANE EAGAN, MN 55123

(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 23 interview with the MM-P indicated the following: -Record review indicated that the licensee did not provide employee training on the fire safety and evacuation plan twice per year after the initial hire training. Records were requested but no records were available or provided for review. -Record review indicated that the licensee did not provide a record of the annual training to residents who can assist in their own evacuation on the proper actions to take in the event of a fire including movement, evacuation, or relocation. Records were requested but no records were available or provided for review. On June 8, 2023, at approximately 2:45 p.m., during the exit interview, the MM-P acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC);	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30683	A. BUILDING: _____ B. WING _____	06/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAGAN	1365 CRESTRIDGE LANE EAGAN, MN 55123

(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
01470	Continued From page 24 (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30683	A. BUILDING: _____ B. WING _____	06/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAGAN	1365 CRESTRIDGE LANE EAGAN, MN 55123

(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
01470	Continued From page 25 and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employees received orientation to include all required content for one of two employees (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 was hired October 7, 2019, and began providing assisted living services to residents August 1, 2021. On June 6, 2023, at 7:35 a.m., ULP-C was observed to assist R3 with activities of daily living (ADLs). ULP-C's employee record lacked documentation the following orientation topics were completed: -An overview of the appropriate Assisted Living statutes 144 G and rules; -Review of providers policies and procedures; -The assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -The principles of person-centered planning and service delivery and how they apply to direct	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30683	A. BUILDING: _____ B. WING _____	06/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAGAN	1365 CRESTRIDGE LANE EAGAN, MN 55123

(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
01470	Continued From page 26 support services provided by the staff person; -Handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; -Consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and -A review of the types of assisted living services the employee will be providing and the facility's category of licensure. On June 6, 2023, at 12:49 p.m., licensed assisted living director (LALD)-A stated required training was assigned in the online training program by corporate, and then the goal would be to have the employee complete the required training by the due date. LALD-A stated she was hired after the new requirements went into effect, and all employee records were not reviewed yet. The licensee's Orientation and Annual Training Requirements policy, revised August 2021, indicated, "Staff /associates providing and supervising direct Assisted Living services should complete an orientation prior to providing Assisted Living services to residents." The policy further indicated the orientation would include: "a. Overview of MN regulations 144G b. Associates job description reviewed upon hire and during employment if it changes (completed with HR hire processes) c. Facility organization chart and associate roles d. Services offered by facility (uniform checklist disclosure of service) e. [Licensee] Assisted Living policies, procedures,	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30683	A. BUILDING: _____ B. WING _____	06/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAGAN	1365 CRESTRIDGE LANE EAGAN, MN 55123

(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
01470	Continued From page 27 clinical guidelines and How To's f. Handling emergencies g. Reporting and identification of abuse, neglect or financial exploitation of elderly h. Assisted Living bill of rights i. Handling and reporting complaints j. Consumer advocacy services of long term care ombudsman k. Types of services; scope of license l. Providing services to the hard of hearing: Age related hearing loss / Communication strategies / Hearing aids m. Training & competency evaluation of unlicensed staff/associate providing Assisted Living services will be conducted by a registered nurse or an additional qualified instructor with the registered nurse. n. Training & competency evaluation of Medication Technicians providing medication services will be conducted by a registered nurse, or an additional qualified instructor with the registered nurse. o. Retraining of associates will occur for assigned tasks when the associate does not demonstrate competency in assigned tasks this may be upon hire, or through observation. If competency does not occur after re-training, the associate would be required to work along with someone deemed competent until competency is achieved. p. The principles of person-centered planning and service delivery and how they apply to direct support services. q. Orientation to resident- Associates providing assisted living services must be oriented specifically to each individual resident and the services to be provided. This may be provided in person, orally, in writing or electronically." No further information was provided.	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30683	A. BUILDING: _____ B. WING _____	06/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAGAN	1365 CRESTRIDGE LANE EAGAN, MN 55123

(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
01470	Continued From page 28 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30683	A. BUILDING: _____ B. WING _____	06/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAGAN	1365 CRESTRIDGE LANE EAGAN, MN 55123

(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
01500	Continued From page 29 (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employees received at least eight hours of annual training for each 12 months of employment for one of two employees (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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:	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30683	A. BUILDING: _____ B. WING _____	06/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAGAN	1365 CRESTRIDGE LANE EAGAN, MN 55123

(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
01500	Continued From page 30 ULP-C was hired October 7, 2019, and began providing assisted living services to residents August 1, 2021. On June 6, 2023, at 7:35 a.m., ULP-C was observed to assist R3 with activities of daily living (ADLs). ULP-C's employee record lacked documentation of eight hours of annual training completed within the last 12 months, including the following required topics: -review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; -review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On June 6, 2023, at 12:49 p.m., licensed assisted living director (LALD)-A stated required training was assigned in the online training program by corporate, and then the goal would be to have the employee complete the required training by the due date. LALD-A stated she was hired after the	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30683	A. BUILDING: _____ B. WING _____	06/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAGAN	1365 CRESTRIDGE LANE EAGAN, MN 55123

(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
01500	Continued From page 31 new requirements went into effect, and all employee records were not reviewed yet. LALD-A further stated ULP-C had not completed the assigned annual training, and they were developing a more reliable way to track completion of annual training by all employees. The licensee's Orientation and Annual Training Requirements policy, revised August 2021, indicated, "Annual training for all Assisted Living communities (8 hrs. in a 12 months period) includes: a. Reporting abuse, neglect or exploitation of elderly b. Assisted Living bill of rights c. Infection control techniques & standards for handwashing, need and use of gloves and other Personal Protective Equipment (PPE), bloodborne pathogens, disposal of contaminated material and equipment, disinfecting reusable equipment and environmental surfaces, and reporting of communicable diseases. d. [Licensee] policies and procedures e. Providing services to the hard of hearing i. Age related hearing loss ii. Communication strategies and health impacts of untreated hearing loss ii. Hearing aids and other technology for those with hearing loss f. Effective approaches to problem-solving challenging behaviors and how to communicate with residents who have dementia, Alzheimer's disease or related disorders. g. The principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30683	A. BUILDING: _____ B. WING _____	06/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAGAN	1365 CRESTRIDGE LANE EAGAN, MN 55123

(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
01500	Continued From page 32 (21) days	01500		
01540 SS=D	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. 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 observation, interview and record review, the licensee failed to ensure direct-care staff completed the required amount of dementia care training in the required time frame for one of two employees (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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	01540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30683	A. BUILDING: _____ B. WING _____	06/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAGAN	1365 CRESTRIDGE LANE EAGAN, MN 55123

(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
01540	Continued From page 33 only occasionally). The findings include: The licensee had a current Assisted Living Facility with Dementia Care (ALFDC) license effective August 1, 2021. ULP-C was hired October 7, 2019, and began providing assisted living services to residents August 1, 2021. On June 6, 2023, at 7:35 a.m., ULP-C was observed to assist R3 with activities of daily living (ADLs). ULP-C's employee record lacked documentation of eight hours initial dementia care training including: (1) an explanation of Alzheimer's disease and other dementias; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; (4) communication skills; and (5) person-centered planning and service delivery. ULP-C's record further lacked documentation of two hours annual dementia care training completed in the last 12 months. On June 6, 2023, at 12:49 p.m., licensed assisted living director (LALD)-A stated required training was assigned in the online training program by corporate, and then the goal would be to have the employee complete the required training by the due date. LALD-A stated she was hired after the new requirements went into effect, and all employee records were not reviewed yet. LALD-A further stated ULP-C had not completed the	01540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30683	A. BUILDING: _____ B. WING _____	06/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAGAN	1365 CRESTRIDGE LANE EAGAN, MN 55123

(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
01540	Continued From page 34 assigned annual training, and they were developing a more reliable way to track completion of annual training by all employees. The licensee's Orientation and Annual Training Requirements policy, revised August 2021, indicated Dementia care training requirements included, "Supervisors of direct care, direct care associates must have 8 hours within 160 working hours on required topics .. Assisted living with dementia care must have 8 hours within 80 working hours of employment start date. Non direct care associates must have 4 hours within 160 hours of start date." The policy further indicated the initial training would include: a. Current explanation of Alzheimer's disease & other dementias; b. Effective approaches to problem solve challenging behaviors; c. How to communicate with the residents; d. Assistance with Activities of Daily Living; and e. Person center planning and service delivery. The policy further indicated, "Each associate, direct care supervisors, direct care associates, non-direct care associates and assisted living with dementia care will have at least 2 hours every 12 months." No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30683	A. BUILDING: _____ B. WING _____	06/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAGAN	1365 CRESTRIDGE LANE EAGAN, MN 55123

(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
01650	Continued From page 35 service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included the required content for three of three residents (R2, R3, R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30683	A. BUILDING: _____ B. WING _____	06/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAGAN	1365 CRESTRIDGE LANE EAGAN, MN 55123

(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
01650	Continued From page 36 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 R2 had diagnoses including Alzheimer's dementia, and obesity. R2's service plan, dated April 10, 2023, indicated R2 received services including assistance with medication management, catheter care, toileting, dressing and grooming, cognitive/psychosocial needs, behavior management, housekeeping, and laundry. R3 R3 had diagnoses including dementia and paraplegia (impairment of the lower extremities). R3's service plan, dated May 30, 2023, indicated R3 received services including assistance with medication management, dressing and grooming, toileting, transfers, cognitive/psychosocial needs, housekeeping, and laundry. R6 R6 had diagnoses including Alzheimer's dementia and mood disorder. R6's service plan, dated March 27, 2023, indicated R6 received services including assistance with dressing and grooming, medication management, bathing, escort and mobility, housekeeping, and laundry. R2, R3, and R6's service plans lacked the following required content: -the frequency of each service, according to the resident's current assessment and resident	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30683	A. BUILDING: _____ B. WING _____	06/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAGAN	1365 CRESTRIDGE LANE EAGAN, MN 55123

(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
01650	Continued From page 37 preferences; and -the method of ongoing assessments of the resident. On June 7, 2023, at 2:05 p.m., clinical nurse supervisor (CNS)-B stated she realized the service plan needed updating, but she had not learned or been trained on the specific requirements. CNS-B further stated forms were developed on a corporate level and would need to be updated to satisfy the statutory requirements. The licensee's Service Plan Process policy, revised August 2021, indicated the service plan should include: "a. A description of the services to be provided, b. The fees for services, c. And the frequency of each service, according to the resident's current assessment and resident preferences, d. Identification of the staff or categories of staff who will provide the services. i. [Licensee] may use "universal workers" to provide for the scheduled and unscheduled needs of the resident that are not related to clinical needs. e. The schedule and methods of monitoring assessments of the resident i. Schedules and methods of monitoring reviews and assessments of the resident are often comprised on on-line programs for tracking of due dates for assessments and those coming due. Additionally, [Licensee] utilizes the Collaborative Care Review process and stand-up meetings to identify changes in condition that may indicate the need for revision to the service plan. Changes in condition not anticipated to be resolved within two weeks, may require an update to the service plan. f. The schedule and methods of monitoring staff	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30683	A. BUILDING: _____ B. WING _____	06/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAGAN	1365 CRESTRIDGE LANE EAGAN, MN 55123

(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
01650	Continued From page 38 providing services; and g. A contingency plan that includes: i. The action to be taken if the scheduled service cannot be provided; ii. Information and a method for a resident or resident's representative to contact the provider. iii. Names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition-including identification of and information as to whom the resident is delegating the authority to sign for the client in an emergency iv. The circumstances in which emergency medical services are NOT to be summoned consistent with state regulation, and declarations made by the resident reflecting their wishes." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided;	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30683	A. BUILDING: _____ B. WING _____	06/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAGAN	1365 CRESTRIDGE LANE EAGAN, MN 55123

(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
01940	Continued From page 39 (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for two of three residents (R3, R6) receiving treatment services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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: R3	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30683	A. BUILDING: _____ B. WING _____	06/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAGAN	1365 CRESTRIDGE LANE EAGAN, MN 55123

(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
01940	Continued From page 40 R3 had diagnoses including dementia and paraplegia (impairment of the lower extremities). On June 6, 2023, at 7:37 a.m., unlicensed personnel (ULP)-C and ULP-D were observed assisting R3 with activities of daily living (ADLs) and mechanical lift transfer. R3's left foot was observed to have an intact, clean dressing, initialed and dated June 2, 2023. ULP-D placed a sock over R3's bandaged left foot. ULP-D stated hospice handles all wound care and dressing for R3, but if the dressing appeared soiled or came loose, she would notify the nurse, and would cleanse with wound cleanser and wrap with gauze. -the surveyor observed a sign in place above R3's bed indicating, "Attention staff [R3] has a wound on her heel Wound care on heel will be completed by hospice 3x/week We need to be floating the heel at all times ie: in bed and in wheelchair Notify nursing of any changes". On June 6, 2023, at 3:46 p.m., ULP-D stated R3 had a foam boot she wore when she went to bed at night, but she would often pull the boot off. ULP-D further stated those type of directions were usually in the medication administration record (MAR), but she knew about R3's boot wearing schedule by word of mouth. R3's record included a physician rounding form dated April 10, 2023, indicating, "Open blister area on heel" and "Continue hospice & wound cares". R3's record included a prescriber order dated June 2, 2023, indicating wound care instructions to be performed twice weekly to the left heel. The order further indicated, "put purple heel protector	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30683	A. BUILDING: _____ B. WING _____	06/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAGAN	1365 CRESTRIDGE LANE EAGAN, MN 55123

(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
01940	Continued From page 41 over secure with velcro [sic]" and "change weekly and PRN [as needed]". R3's service plan, dated May 30, 2023, indicated R3 received services including assistance with medication management, dressing and grooming, toileting, transfers, cognitive/psychosocial needs, housekeeping, and laundry. The service plan further indicated, "Resident is able to perform the following tasks with physical assistance as needed:" and included, "-Other night time boot." The service plan lacked further information related to the boot and lacked any information related to wound care services. R3's record lacked a treatment and therapy management plan for wound care and protective foam boot with the following required content: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On June 6, 2023, at 4:12 p.m., clinical nurse supervisor (CNS)-B stated they tracked R3's wound in the skin assessment. CNS-B further stated there should have been instructions in the	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30683	A. BUILDING: _____ B. WING _____	06/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAGAN	1365 CRESTRIDGE LANE EAGAN, MN 55123

(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
01940	Continued From page 42 shift task list for ULPs so they knew what to do if necessary regarding R3's wound care. CNS-B added licensed practical nurse (LPN)-E usually created a document to post in the resident's room with instructions for ULPs. On June 6, 2023, at 4:40 p.m., licensed assisted living director (LALD)-A stated R3's service plan was updated recently, but confirmed the only change made was to discontinue catheter cares for R3, and wound care or wearing of a foam boot had not been added to the service plan. On June 7, 2023, at 9:32 a.m., LPN-E stated the order regarding the foam boot needed further clarification regarding the wearing schedule. LPN-E agreed there should be better instruction for the ULPs, and would be clarifying the order. R6 R6 had diagnoses including Alzheimer's dementia and mood disorder. On June 6, 2023, at 8:40 a.m., ULP-G assisted R6 with applying thrombo-embolus deterrent (TED) stockings (compression stockings to assist with blood flow) to both lower legs. R6's record included a provider order for TED stockings, dated March 13, 2023. R6's cares documentation for June 1-5, 2023, indicated R6 received assistance with application of TED stockings daily on June 1-5, 2023. R6's service plan, dated March 27, 2023, indicated R6 received services including assistance with dressing and grooming, medication management, bathing, escort and mobility, housekeeping, and laundry. R6's service	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30683	A. BUILDING: _____ B. WING _____	06/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAGAN	1365 CRESTRIDGE LANE EAGAN, MN 55123

(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
01940	Continued From page 43 plan lacked information related to R6's use of TED stockings. R6's record lacked a treatment or therapy management plan for the use of TED stockings with the following required content: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On June 7, 2023, at 2:05 p.m., CNS-B stated she realized the service plans needed updating, but she had not learned or been trained on the specific requirements. The licensee's Treatment or Therapy Management Services policy, revised February 2023, indicated, "Treatment or Therapy Management Service Plan should be completed by a Registered Nurse (RN), face to face upon admission/move-in, every 90-days and with any changes. The individualized treatment or therapy management plan is to be included in the Service plan with client specific instructions." The policy further indicated, "1. When identified that a resident would benefit	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30683	A. BUILDING: _____ B. WING _____	06/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAGAN	1365 CRESTRIDGE LANE EAGAN, MN 55123

(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
01940	Continued From page 44 from treatment or therapy service, nursing will contact the resident's physician/healthcare provider to obtain an order for such services. A licensed nurse may obtain the physician/healthcare provider order in writing, electronically or verbally. The nurse receiving the order should implement a treatment or therapy plan within 24 hours of receipt and educate the resident or responsible party before treatment or therapies are initiated. 2. The RN or Licensed Practical Nurse (LPN) should assign treatment orders to unlicensed personnel (ULP) who have been delegated, show competence and possess the knowledge and skills consistent with the treatment by an RN. 3. LPNs or ULP should follow resident specific instructions for treatment(s) as indicated on Therapy or Treatment Management Plan and Delegated Tasks sheets. Documentation of the services should be noted on the AOL sheet or Medication Administration Record (MAR/eMAR)/Treatment Administration Record (TAR/eTAR). 4. ULP should notify nursing if a resident refuses treatment or therapy services, if a resident no longer requires assistance with treatment or therapy services, or when a resident needs additional assistance. Resident refusals should be reported to the licensed nurse. In the event treatment or services are omitted for any reason, the licensed nurse is to be notified. 5. The licensed nurse should contact the resident's physician/healthcare provider and responsible party for omitted treatments. 6. A registered nurse should periodically monitor and evaluate treatments and therapies that are provided to each resident upon change of condition and at least every 90 days." No further information was provided.	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30683	A. BUILDING: _____ B. WING _____	06/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EAGAN	1365 CRESTRIDGE LANE EAGAN, MN 55123

(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
01940	Continued From page 45 TIME PERIOD FOR CORRECTION: Seven (7) days	01940		

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

Type: Full
Date: *06/06/23*
Time: 10:00:00
Report: 1005231109

Food and Beverage Establishment Inspection Report

Location:
Brookdale Eagan
1365 Crestridge Lane
Eagan, MN55123
Dakota County, 19

Establishment Info:
ID #: 0039001
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6516865557
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.

2-200 Employee Health

2-201.11C ***** Priority 1 *****

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.

THERE IS NO EMPLOYEE ILLNESS LOG ON SITE. REVIEWED REQUIREMENTS WITH MANAGER, A LOG WILL BE SENT WITH REPORT.

Comply By: 06/06/23

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.

THERE IS NO INDICATOR ON SITE TO TEST THE UTENSIL SURFACE TEMPERATURE IN THE DISH MACHINE.

Comply By: 06/13/23

4-300 Equipment Numbers and Capacities

4-302.14 ***** Priority 2 *****

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

THE QUATERNARY AMMONIUM TEST STRIPS WERE EXPIRED AND FADED. PROVIDE NEW TEST STRIPS.

Comply By: 06/13/23

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200+PPM at Degrees Fahrenheit
Location: 3-COMP DISPENSER
Violation Issued: No

Utensil Surface Temp.: = at 175 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/POTATO SALAD
Temperature: 35 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Hold/CHICKEN SALAD
Temperature: 35 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Hold/CHEESE
Temperature: 36 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cooking/SLICED STEAK
Temperature: 194 Degrees Fahrenheit - Location: STOVETOP
Violation Issued: No

Process/Item: Cold Hold/MILK
Temperature: 41 Degrees Fahrenheit - Location: COOLER SERVER STATION 1
Violation Issued: No

Process/Item: Cold Hold/MILK
Temperature: 34 Degrees Fahrenheit - Location: COOLER SERVER STATION 2
Violation Issued: No

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

INSPECTION COMPLETED WITH MANAGER AND REVIEWED WITH NURSE EVALUATOR RENEE ANDERSON.

REVIEWED SYMPTOMS OF FOODBORNE ILLNESSES AND THE REQUIREMENT TO MAINTAIN AN EMPLOYEE ILLNESS LOG OF THOSE INSTANCES WHEN EMPLOYEES ARE ILL WITH VOMITING OR DIARRHEA "AND" IMMEDIATELY EXCLUDE FROM THE FOOD ESTABLISHMENT ANY FOOD EMPLOYEE ILL WITH VOMITING OR DIARRHEA. EMPLOYEES MUST BE EXCLUDED FOR AT LEAST 24 HOURS AFTER LAST SYMPTOM.

Type: Full
Date: *06/06/23*
Time: 10:00:00
Report: 1005231109
Brookdale Eagan

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 1005231109 of 06/06/23.

Certified Food Protection Manager: ERIC DICKERSON

Certification Number: FM113960 Expires: 07/13/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
ERIC DICKERSON
KITCHEN MANAGER

Signed: _____
Jessica Davis
Public Health Sanitarian III
651-201-3961
jessica.davis@state.mn.us