Electronically Delivered

July 14, 2023

Licensee
Brookdale Eden Prairie
7513 Mitchell Road
Eden Prairie, MN 55344

RE: Project Number(s) SL30691015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 13, 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.

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

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. 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,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 651-215-6894 / 651-281-9796

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30691	A. BUILDING: _____ B. WING _____	06/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EDEN PRAIRIE	7513 MITCHELL ROAD EDEN PRAIRIE, MN 55344

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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: SL30691015 On June 12, 2023, through June 13, 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 thirty-one (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		

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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 31 residents in the Assisted Living with Dementia Care 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 13, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=D	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.	0 510		

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0 510	Continued From page 2 (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) 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 an infection control program that complies with accepted health care, medical, and nursing standards for infection control. The deficient practice had the potential to affect all residents, employees, 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 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: On June 12, 2023, at 11:48 a.m., the surveyor observed unlicensed personnel (ULP)-B provide medication and treatment administration to R3, which included blood glucose testing and insulin administration. ULP-B did not perform hand hygiene when donning (putting on) and doffing (taking off) gloves. During observation on June 12, 2023, at 11:55	0 510		

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0 510	Continued From page 3 a.m., the surveyor noted ULP-B was wearing gloves when surveyor approached. ULP-B stated she had sanitized her hands with sanitizer before donning (putting on) gloves. ULP-B obtained R3's blood glucose meter from R3's locked medication drawer. ULP-B took a lancet auto injector from a box as well as two alcohol wipes. ULP-B locked the medication cart, brought the blood glucose meter, alcohol wipes, and the finger lancet auto injector to R3 who was sitting at a dining room table. ULP-B obtained R3's blood glucose level then proceeded to return to the medication cart, doffed (removed) the glove on the left hand, removed the needle from the finger lancet injector with right hand, placed it in a hazardous waste container, removed the glove on right hand, and proceeded to document in the electronic medical record (EMAR). ULP-B went to get another pair of gloves from the box on the medication cart. ULP-B donned the gloves, took a prescription card from the medication cart, and popped a tablet out of the card into a paper medication cup. ULP-B closed the medication drawer and locked the medication cart. ULP-B approached and gave R6 the medication cup and told R6 to place the pill in their mouth and chew the medication. After administration, ULP-B returned and opened the medication cart, doffed the gloves, and documented administration in the EMAR. ULP-B donned a new pair of gloves and gathered supplies to complete insulin administration for R3. ULP-B gathered an alcohol wipe, wiped off the insulin pen, placed a needle on the pen, dialed the pen to 2 and depressed the pen dispensing insulin into the garbage can. ULP-B locked the medication cart and returned to R3. ULP-B asked R3 to stand and remove jacket from left arm. ULP-B then administered insulin into R3's left deltoid after cleansing the area with an alcohol wipe. After administering the insulin,	0 510		

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0 510	Continued From page 4 ULP-B returned to the medication cart, removed the needle from the insulin pen and placed it into a hazardous waste container. ULP-B then doffed gloves and placed them in the trash. ULP-B documented administration in the EMAR and proceeded with the next scheduled medication administration. ULP-B did not wash or sanitize hands when donning or doffing gloves. On June 12, 2023, at 12:20 p.m., ULP-B stated she had been employed with the licensee for 5 years. ULP-B stated she was trained by a registered nurse (RN) and had to show the RN that she was able to administer medications and treatments. When asked about hand hygiene, ULP-B stated she was also trained by the RN how to correctly wash hands and use hand sanitizer. On June 13, 2023, director of nursing (DON)-A was notified of ULP-B not performing hand hygiene before or after application of donning or doffing gloves. DON-A stated all ULPs had been trained and instructed to wash hands. DON-A stated she frequently did visual audits to ensure hand hygiene was being completed. DON-A stated she did not document these audits. The licensee's Handwashing policy dated October 2021, indicated handwashing would be performed before and after any gloving. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 650 SS=D	144G.42 Subd. 8 Employee records	0 650		

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0 650	Continued From page 5 (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure current employee records were maintained to include all required content for one of two employees (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or	0 650		

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0 650	Continued From page 6 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-B was hired September 7, 2017, to provide direct care and services to the licensee's residents. ULP-B's employee file lacked the following required content: -current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; and -annual performance employee review. On June 13, 2023, at approximately 2:10 p.m., licensed assisted living director (LALD)-D reviewed ULP-B's employee records. LALD-D confirmed ULP-B's record was missing the above-mentioned required content and could not answer as to why they were not included. LALD-D stated it was routine for supervisors to complete annual employee reviews for each ULP. The licensee's Employee Records policy dated, August 1, 2021, indicated employee records would include evidence of professional licensure and a current signed job description. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a	0 660		

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0 660	Continued From page 7 comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included completion of a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test for two of two employees (director of nursing (DON)-A, unlicensed personnel (ULP)-B). 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:	0 660		

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0 660	Continued From page 8 The licensee's TB risk assessment dated August 1, 2022, indicated the licensee was a low risk setting for TB transmission. DON-A had a hire date of September 19, 2022. DON-A provided direct care to residents of the assisted living. DON-A's employee record lacked a completed TB screening form and documentation of a two-step TST or other evidence of TB screening such as a blood test. ULP-B had a hire date of September 17, 2017. ULP-B provided direct care to residents of the assisted living. ULP-B's employee record lacked a completed TB screening form and documentation of a two-step TST or other evidence of TB screening such as a blood test. During an interview on June 13, 2023, at 11:30 a.m., licensed assisted living director (LALD)-C stated she was not aware DON-A or ULP-B did not have evidence of TB screening or TB testing. DON-A stated she would need to speak with the staff member responsible for ensuring employee TB screening and testing results were in the employee files. The Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, noted baseline screening for all health care workers (HCW) included a history and symptom screen, and testing for the presence of TB infection. The regulations noted a blood test should include the date of the test. The licensee's Employee Tuberculosis Prevention	0 660		

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0 660	Continued From page 9 and Control policy was requested but not received. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. 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	0 800		

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0 800	Continued From page 10 a large portion or all of the residents). Findings include: On June 14, 2023, at approximately 10:30 a.m., survey staff toured the facility with the Assisted Living Director (LALD)-C and the Maintenance Manager (MM)-D. During the facility tour, survey staff observed the following items: Clare Side In the parlor room, it was observed that the posted fire safety and evacuation plans were not accurate depictions of the egress route and were not matched to the installed overhead exit signage location. The parlor door did not have an overhead exit sign, but it was identified as an exit on the posted evacuation plan. The exit sign was installed in the room but pointed to the adjacent wall without any exit door. In the dining room, it was observed that extensive mold or similar black substance on the supply air grille. Mold in the room housed by air distribution equipment has the potential to circulate mold throughout the floor served by that equipment. In the C wing corridor, it was observed that the fire-rated dining room door with a magnetic hold open did not close or positively latch when the magenta was released from the open position. The door was detaching from the frame due to a loose hinge. Door magnets release the door from the open position in the event of a fire, and the door must positively latch to protect the occupants and to contain the spread of fire. In the rated furnace room in the C wing, it was observed that the furnace room doorknob was	0 800		

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0 800	Continued From page 11 removed, and there was a hole in the door. The furnace door was fire rated door, and the facility must maintain the fire resistance integrity of the door assembly. In the bathing room, it was observed that the toilet flush valve was missing, and the toilet did not function. In the storage within the laundry room, it was observed that the ceiling-mounted light fixture was broken with a missing cover. And it was also observed that the room door closer was removed, and the doorknob was missing. In the rated furnace room in the B wing, it was observed that the furnace room doorknob was removed, and there was a hole in the door. The furnace door was fire rated door, and the facility must maintain the fire resistance integrity of the door assembly. In the county kitchen, it was observed that the electrical box for the microwave was not attached and hung loose from the wall. In the county kitchen, it was observed that the closers on the door had been disabled by removing the closure arm or closure device. The door still had a portion or remnants of the closure device still mounted on the door. It was also observed that the hold-open magnet armature was removed from the door. Door magnets release the door from the open position in the event of a fire and allow it to close to protect the occupants and to contain the spread of fire. In the vestibule to the enclosed outdoor space, it was observed that the door screen was ripped, and the window wood frame was significantly	0 800		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 800	Continued From page 12 rotten. In the enclosed outdoor space, it was observed that the concrete paver was uneven and shifted out of even elevation by an inch at some locations. The uneven finish condition created a tripping hazard for all residents. In the rated furnace room in the A wing, it was observed that the furnace room doorknob was removed, and there was a hole in the door. The furnace door was fire rated door, and the facility must maintain the fire resistance integrity of the door assembly. In the storage within the laundry room in the A wing, it was observed that the storage room door closer was removed, and the doorknob was missing. In the wall between the storage room and laundry room, it was observed that the wall had a large hole in the sheetrock wall. This wall is part of a fire barrier and is required to maintain fire resistance integrity. Bridge Side In the county kitchen, it was observed that the closers on the door had been disabled by removing the closure arm or closure device. The door still had a portion or remnants of the closure device still mounted on the door. It was also observed that the hold-open magnet armature was removed from the door also, and the door was propped open. Door magnets release the door from the open position in the event of a fire and allow it to close to protect the occupants and to contain the spread of fire.	0 800		

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	30691	A. BUILDING: _____ B. WING _____	06/13/2023

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0 800	Continued From page 13 In the housekeeping room within the laundry room in the D wing, it was observed that the room door was stuck to the tile floor, and the door was not fully open. It was also observed that the doorknob was removed, and there was a hole in the door. In the rated furnace room in the A wing, it was observed that the furnace room doorknob was removed, and there was a hole in the door. The furnace door was fire rated door, and the facility must maintain the fire resistance integrity of the door assembly. It was also observed that the furnace door in the F wing, the E wing, and the D wing were in the same condition as the furnace door in the A wing. In the Sprinkler riser room, the room door did not close due to the hardware did not latch correctly. The door was a fire-rated door, and the rated door should close and latch completely to maintain the fire resistance integrity of the room. In the kitchen dry storage, it was observed that the door from the corridor was propped open with a kick-down door stop. The kick-down doorstop will prevent the door from closing in the event of a fire. In the restroom within the staff break room, it was observed that the door was sticking badly to the floor, and the door did not open fully. In the kitchen and food storage area, it was observed that mold or similar black substance was on the supply air grille. Mold in the room housed by air distribution equipment has the potential to circulate mold throughout the floor served by that equipment. During the facility tour, LALD-C and MM-D	0 800		

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0 800	Continued From page 14 visually verified these deficient findings at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and	01620		

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01620	Continued From page 15 reassessment to include all areas required on the uniform assessment tool per Minnesota Rules 4659.0150 for three of three residents (R1, R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R1 was admitted on April 17, 2023. R1's Service Plan dated May 8, 2023, indicated R1 received services to include medication administration, treatments, assistance with activities of daily living (bathing, grooming) and monitoring and reassessment. R1's record included documentation of nursing assessments completed on April 17, 2023, and May 2, 2023. R1's Comprehensive Home Care Monitoring and Reassessment lacked areas required on the uniform assessment tool including: - the resident's personal lifestyle preferences; - activities of daily living; - instrumental activities of daily living; - physical health status; - emotional and mental health conditions; - communication and sensory capabilities; - pain; - skin conditions; - nutritional and hydration status and preferences;	01620		

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01620	Continued From page 16 - list of treatments, including type, frequency, and level of assistance needed; - nursing needs, including potential to receive nursing-delegated services; - risk indicators; and - the need for follow-up referrals for additional medical or cognitive care by health professionals. R2 was admitted January 9, 2017. R2's Service Plan dated November 14, 2022, indicated R2 received services to include medication administration, treatments, assistance with activities of daily living (dressing, bathing, grooming bathroom assistance, ambulation assistance) and monitoring and reassessment. R2's record included documentation of nursing assessments completed on November 2, 2022, February 2, 2023, and May 2, 2023. R2's Comprehensive Home Care Monitoring and Reassessment lacked areas required on the uniform assessment tool including: - the resident's personal lifestyle preferences; - activities of daily living; - instrumental activities of daily living; - physical health status; - emotional and mental health conditions; - communication and sensory capabilities; - pain; - skin conditions; - nutritional and hydration status and preferences; - list of treatments, including type, frequency, and level of assistance needed; - nursing needs, including potential to receive nursing-delegated services; - risk indicators; and - the need for follow-up referrals for additional medical or cognitive care by health professionals.	01620		

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01620	Continued From page 17 R3 was admitted on December 29, 2022. R3's Service Plan dated April 13, 2023, indicated R3 received services to include medication administration, treatments, chronic condition management, assistance with activities of daily living (bathing) and monitoring and reassessment. R3's record included documentation of nursing assessments completed on January 26, 2023, and April 15, 2023. R3's Comprehensive Home Care Monitoring and Reassessment lacked areas required on the uniform assessment tool including: - the resident's personal lifestyle preferences; - activities of daily living; - instrumental activities of daily living; - physical health status; - emotional and mental health conditions; - communication and sensory capabilities; - pain; - skin conditions; - nutritional and hydration status and preferences; - list of treatments, including type, frequency, and level of assistance needed; - nursing needs, including potential to receive nursing-delegated services; - risk indicators; and - the need for follow-up referrals for additional medical or cognitive care by health professionals. On June 12, 2023, at 12:10 p.m., director of nursing (DON)-A acknowledged the licensee's assessments did not use the uniform assessment tool. In addition, DON-A stated they were overwhelmed with the number of assessments they had to complete and questioned what assessments a licensed practical nurse could complete. DON-A stated they were completing	01620		

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01620	Continued From page 18 assessments for all residents and was attempting to get the assessments up to date. DON-A also stated the same assessment tool was used for all the licensee's residents. The licensee's PL.6-005 RN Assessment and Reassessment policy dated December 2020, indicated the assessment should determine client problems, needs, goals, and anticipated discharge needs. The policy did not indicate the Uniform Assessment Tool requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees	01640		

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01640	Continued From page 19 when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure service plans included signatures or other authentication by the residents and the licensee to document agreement on the services to be provided for three of three residents (R1, R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted to the licensee on April 17, 2023. R1's diagnoses included Alzheimer's disease. R1's Service Plan dated May 8, 2023, indicated R1 received services to include medication administration, treatments, assistance with activities of daily living (bathing, grooming) and monitoring and reassessment. R1's record lacked a signed and dated service plan acknowledging agreement of the services to be provided. R2	01640		

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01640	Continued From page 20 R2 was admitted to the licensee on January 9, 2017. R2's diagnoses included dementia. R2's Service Plan dated November 14, 2022, indicated R2 received services to include medication administration, treatments, assistance with activities of daily living (dressing, bathing, grooming bathroom assistance, ambulation assistance) and monitoring and reassessment. R2's record lacked a signed and dated service plan acknowledging agreement of the services to be provided. R3 R3 was admitted to the licensee on December 29, 2022. R3's diagnoses included impaired cognitive function. R3's Service Plan dated April 13, 2023, indicated R3 received services to include medication administration, treatments, chronic condition management, assistance with activities of daily living (bathing) and monitoring and reassessment. R3's record lacked a signed and dated service plan acknowledging agreement of the services to be provided. On June 13, 2023, at 12:40 p.m., director of nursing (DON)-A stated residents or residents' representatives were responsible to sign the service agreement. DON-A stated she was aware that the service agreements had not been signed and stated she had been attempting to get resident's representatives to acknowledgment and sign the service agreements. DON-A could not provide documentation that she had attempted to obtain signatures from resident's	01640		

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01640	Continued From page 21 representatives. The licensee's Service Plan policy dated August 1, 2021, indicated the service plan and any revisions would include a signature or other authentication by the licensee and by the resident, or resident's representative, documenting agreement on the services to be provided. TIME PERIOD TO CORRECT: Twenty-one (21) days	01640		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications had a prescription label with the original prescription indicating who the medication was for and the direction for administration for over-the-counter (OTC) medications. 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	01890		

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01890	Continued From page 22 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On June 12, 2023, at 11:40 a.m., the surveyor observed the contents of the locked medication cart and verified the contents with unlicensed personnel (ULP)-B. The surveyor observed the following: - melatonin supplement bottle lacked a label indicating whom the medication was for as well as directions for medication administration; - calcium plus vitamin D3 supplement bottle lacked a label indicating whom the medication was for as well as directions for medication administration; and - omega XL supplement bottle lacked a label indicating whom the medication was for as well as directions for medication administration During an interview on June 12, at 11:50 a.m., ULP-B stated she was aware of who received the medications as they were documented in the electronic medication administration record (EMAR). ULP-B was not aware of the need to have a label on OTC medications. During interview on June 12, 2023, at 1:45 p.m., director of nursing (DON)-A verified and acknowledged that the bottles did not have any identifying information or directions for use. DON-A stated that she would not know whom the medications were for if there was not an EMAR. The licensee's Medication and Treatments Labeling policy dated March 2023, indicated all medications and treatments (including OTC and sample medications) should be labeled with the necessary information to provide safe medication	01890		

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01890	Continued From page 23 management administration/assistance. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide a hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property for the facility. This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic	02040		

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02040	Continued From page 24 failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review of the available documentation and interview was conducted on June 14, 2023, at approximately 10:30 a.m. with the Assisted Living Director (LALD)-C and the Maintenance Manager (MM)-D on the hazard vulnerability assessment for the physical environment of the facility. The record review indicated that the licensee had not performed a hazard vulnerability assessment with mitigation factors on and around the property. During the interview, LALD-C and MM-D stated that the licensee had not performed a hazard vulnerability assessment for the physical environment on or around the property. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02410 SS=D	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the	02410		

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02410	Continued From page 25 unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure privacy was maintained for one of one resident (R3) observed during medication and treatment administration. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On June 12, 2023, at 11:50 a.m., R3 was seated in the common dining area eating lunch with other residents. Unlicensed personnel (ULP)-B approached R3 carrying supplies to complete a blood glucose monitoring check. ULP-B advised R3 they be administering a blood glucose check. R3 was chewing their food when ULP-B announced what they would be doing. R3	02410		

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02410	Continued From page 26 finished chewing their food and pointed their right ring finger for ULP-B to conduct the blood glucose check while at the dining table with other residents. On June 12, 2023, at 12:15 p.m., ULP-B locked the medication cart and returned to R3, who was sitting at the dining table with other residents. ULP-B asked R3 to stand and remove jacket from left arm. ULP-B then administered insulin into R3's left deltoid after cleansing the area with an alcohol wipe. On June 12, 2023 at 12:52 p.m., director of nursing (DON)-A stated she was not aware residents' privacy was impacted if medication administration or blood glucose testing was completed in the dining area during meals. The licensee's Medication and Treatment Administration policy dated March 31, 2022, lacked instructions for providing privacy during medication or treatment administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02410		

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

Type: Full
Date: *06/13/23*
Time: 10:00:00
Report: 1005231112

Food and Beverage Establishment Inspection Report

Location:
Brookdale Eden Prairie
7513 Mitchell Road
Eden Prairie, MN55344
Hennepin County, 27

Establishment Info:
ID #: 0038169
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9529063800
ID #:

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

The following orders were issued during this inspection.

4-300 Equipment Numbers and Capacities

4-302.13B ** Priority 2 **

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

NO REGISTERING THERMOMETER OR TEMPERATURE TEST STRIPS WERE ON SITE. PROVIDE A DEVICE TO ENSURE THE DISH MACHINE IS PROVIDING A UTENSIL SURFACE TEMPERATURE OF 160dF OR ABOVE.

Comply By: 06/20/23

4-500 Equipment Maintenance and Operation

4-501.11AB

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

COOLER IN KITCHENETTE ACROSS FROM THE KITCHEN HAD AN AMBIENT TEMP OF 47dF. THE ONLY TCS FOOD IN IT WAS MILK, WHICH HAD JUST BEEN MOVED FROM THE WALK-IN AND WAS STILL 41dF. DO NOT STORE TCS FOOD IN THIS COOLER UNTIL IT HAS AMBIENT TEMP OF 41dF OR BELOW.

Comply By: 06/20/23

6-300 Physical Facility Numbers and Capacities

6-301.14A

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

HANDWASHING SIGNS WERE MISSING FROM HAND SINKS IN BOTH SERVER KITCHENETTES.

Type: Full
Date: *06/13/23*
Time: 10:00:00
Report: 1005231112
Brookdale Eden Prairie

Food and Beverage Establishment Inspection Report

Comply By: 06/20/23

Surface and Equipment Sanitizers

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

Utensil Surface Temp.: = at 167 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Veggie Wash: = 7.81PPM at Degrees Fahrenheit
Location: VEGGIE WASH DISPENSER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/CHICKEN
Temperature: 38 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Hold/POTATO SALAD
Temperature: 38 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Hold/BUTTER
Temperature: 38 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Hold/MILK
Temperature: 41 Degrees Fahrenheit - Location: KITCHENETTE 1 (CLOSEST TO KITCHEN)
Violation Issued: No

Process/Item: Cold Hold/AMBIENT
Temperature: 47 Degrees Fahrenheit - Location: KITCHENETTE 1 (CLOSEST TO KITCHEN)
Violation Issued: No

Process/Item: Cold Hold/MILK
Temperature: 38 Degrees Fahrenheit - Location: KITCHENETTE 2
Violation Issued: No

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

INSPECTION COMPLETED WITH KITCHEN MANAGER AND REVIEWED WITH HRD NURSE EVALUATOR ELYSE JONES. DISCUSSED ALL ORDERS ON REPORT.

DISCUSSED COOLING AND EMPLOYEE ILLNESS.

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.

Food and Beverage Establishment Inspection Report

EMPLOYEES MUST BE EXCLUDED FOR AT LEAST 24 HOURS AFTER LAST SYMPTOM.

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 1005231112 of 06/13/23.

Certified Food Protection Manager: CHELSEA R. KALAL

Certification Number: FM108332 Expires: 10/27/24

Inspection report reviewed with person in charge and emailed.

Signed: _____

JONATHEN LOPEZ
KITCHEN MANAGER

Signed: _____

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