Electronically Delivered

July 9, 2026

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

RE: Project Number(s) SL30691016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 4, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

pursuant to this survey:

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00
St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

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

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers.

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,

Renee L. Anderson

Renee L. Anderson, Supervisor
State Evaluation Team
Email: Renee.L.Anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30691	A. BUILDING: _____ B. WING _____	06/04/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	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 COMMENT SL30691016-0 On June 1, 2026, through June 4, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 25 residents; 25 receiving services under the Assisted Living with Dementia Care Facility license. An immediate correction order was identified on June 3, 2026, issued for SL30691016-0, tag identification 2310.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 330 SS=E	144G.30 Subd. 4 Information provided by facility (a) The assisted living facility shall provide	0 330		

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0 330	Continued From page 1 accurate and truthful information to the department during a survey, investigation, or other licensing activities. (b) Upon request of a surveyor, assisted living facilities shall within a reasonable period of time provide a list of current and past residents and their legal representatives and designated representatives that includes addresses and telephone numbers and any other information requested about the services to residents. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide the Minnesota Department of Health (MDH) with accurate and truthful information during a survey, by falsifying the resident record for two of three residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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: Clinical nurse supervisor (CNS)-B was hired February 16, 2026, to provide oversight and guidance to staff and provide direct nursing care and services to residents of the facility. From June 1, 2026, to June 3, 2026, the surveyor observed, throughout the on-site survey period,	0 330		

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0 330	Continued From page 2 CNS-B interacting with the facility residents and employees. R2 R2 was admitted on May 5, 2025, and received assisted living with dementia care services from the licensee. On June 1, 2026, from 12:23 p.m. to 12:55 p.m., the surveyor observed R2's bedroom with unlicensed personnel (ULP)-D and ULP-I. R2's bed included bilateral "Halo"-style consumer bed rails in the upright position attached to a hospital style bed. ULP-D and ULP-I assisted R2 from a Broda wheelchair (a specialized wheelchair for positioning support) to her bed using a Hoyer mechanical lift. R2's Quarterly assessment signed March 11, 2026, indicated the following assessment for assistive devices on page six, "Resident can [no] longer walk, resident is now broader {sic} [Broda] wheelchair bound. need assist of one for locomotion, remind resident to ask for help as needed. Resident re-assessed for need of Halo bed assist rail due to impaired mobility and dependence on staff for bed mobility and transfers. Resident requires two-person assistance and use of a Hoyer lift for transfers. Resident is unable to independently transfer or ambulate. Quarterly Assessment completed, installation of Halo rail still intact. Purpose of device is to provide a stable handhold to assist with repositioning in bed and promote comfort during care. Resident assessed for cognitive status, safety awareness, and potential entrapment risks. Risks and benefits of Halo rail use reviewed with resident and/or responsible party, who verbalized understanding. Halo rail is installed and inspected. Device securely attached	0 330		

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0 330	Continued From page 3 according to manufacturer guidelines. Mattress fit evaluated with no gaps or entrapment hazards identified. Resident observed during care following installation. No signs of discomfort, injury, or unsafe interaction with the device noted. Resident will continue to require two-person assistance and Hoyer lift transfers; Halo rail is not to be used as a transfer device. Care plan updated to reflect use of Halo rail for bed mobility and positioning assistance. Staff instructed to monitor for changes in condition, skin integrity concerns, signs of entrapment, or other safety issues related to device use. Manufacturer instructions and recall information reviewed on 11 Mar. 2026, www.manualslib.com/manual/1558500/Halo-77301.html. No manufacturer recall notices identified at the time of review." It was later determined the documentation related to reviewing manufacturer instructions and recall notices was added to the assessment during the survey. R2's Care Plan dated March 10, 2026, indicated on page five, number 29, "Mobility: Bed Mobility Aide. As of: 03.11.2026 Resident re-assessed for need of Halo bed assist rail due to impaired mobility and dependence on staff for bed mobility and transfers." The care plan included the same remaining wording previously identified in the March 11, 2026, nursing assessment, including, "Manufacturer instructions and recall information reviewed on 11 Mar. 2026, www.manualslib.com/manual/1558500/Halo-77301.html. No manufacturer recall notices identified at the time of review." It was later determined the documentation related to reviewing manufacturer instructions and recall notices was added to the care plan during the survey.	0 330		

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0 330	Continued From page 4 R3 R3 was admitted on October 31, 2024, and received assisted living with dementia care services from the licensee. On June 2, 2026, from 7:15 a.m. to 7:32 a.m., the surveyor observed R3's bedroom with ULP-H. R3's bed included bilateral "Halo"-type consumer bed rails in the upright position attached to a hospital-style bed. R3 was lying on her back in the bed. ULP-H assisted R3 from the bed with a transfer of one, to the wheelchair and into the bathroom to assist with personal cares. R3's Change of Condition assessment dated March 12, 2026, indicated on page six, "3. What type of assistive device does the resident utilize, if any?" "3/11/26 Put on Halo rails which were assessed for safety and brought in by family and is being placed on Hospice with hospital bed and bed table." On June 3, 2026, at 10:50 a.m., CNS-B provided an undated Care Plan for R3, which indicated "Care Plan for [R3] Last updated: 06/03/2026 by [CNS-B]", "Resident is WC bound and needs assistance. and now have {sic} Halo rails. Resident assessed for need of Halo bed assist rail related to impaired mobility and requirement for two-person assistance with transfers and bed mobility. Resident requires extensive assistance for repositioning and transfers in and out of bed. Halo rail recommended to provide a secure handhold for bed mobility and to promote safe transfers while maintaining resident comfort and safety. Prior to installation, resident evaluated for cognitive status, mobility limitations, fall risk, and potential entrapment concerns. Benefits and potential risks of Halo rail use reviewed with	0 330		

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0 330	Continued From page 5 resident and/or responsible party. Resident/responsible party voiced understanding. Halo rail installed and inspected. Device securely attached to bed frame per manufacturer guidelines. Mattress fit assessed with no significant gaps or entrapment hazards noted. Resident observed utilizing rail with staff assistance during bed mobility activities. No signs of distress, injury, or unsafe use observed. Care plan updated to reflect Halo rail use for assistance with bed mobility and transfers. Staff instructed to continue providing two-person assistance for transfers and to monitor for changes in condition, skin integrity issues, fall risk, and safe use of the device. Resident tolerated assessment and installation without incident." On June 3, 2026, at 1:34 p.m., when asked by the surveyor, CNS-B stated she added some bed rail assessment content to both R2 and R3's care plans, during the survey. CNS-B verbalized she made the decision to add the additional bed rail information to the care plan because the licensed assisted living director (LALD)-A informed her the additional information was required. On June 4, 2026, at 10:32 a.m., CNS-B stated, via phone, that during the survey (June 1-4, 2026), she added the last paragraph to R2's assessment and care plan which read, "Manufacturer instructions and recall information reviewed on 11 Mar. 2026, www.manualslib.com/manual/1558500/Halo-77301.html. No manufacturer recall notices identified at the time of review." No further information was provided. TIME PERIOD FOR CORRECTION: Two (2)	0 330		

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0 330	Continued From page 6 days	0 330		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the daily staffing schedule was posted, at the beginning of each work shift, in a central location, accessible to staff, residents,	0 470		

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0 470	Continued From page 7 volunteers, and the public, as required, potentially affecting all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee lacked a posted daily staffing schedule including: -direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked; -identify the direct-care staff members' resident assignments or work location; and -be posted, after redacting direct-care staff member's resident assignments, at the beginning of each work shift in a central location in each building. On June 1, 2026, at 11:03 a.m., during a facility tour with licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B. The facility lacked a current daily staffing schedule posted in a central location of the facility. LALD-A stated he was not aware of this requirement. On June 1, 2026, at 11:13 a.m., business office manager (BOM)-C stated she was not aware the current daily staffing was to be posted in a central location of the facility. BOM-C stated she would work on this right away to ensure this information	0 470		

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0 470	Continued From page 8 was posted as required. On June 1, 2026, at 12:20 p.m., the surveyor observed the daily staffing schedule had been posted near the front reception area, during the survey. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and	0 480		

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0 480	Continued From page 9 clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	0 480		

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0 480	Continued From page 10 cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated June 1, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health.	0 550		

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PRAIRIE HEIGHTS MEMORY CARE	7513 MITCHELL ROAD EDEN PRAIRIE, MN 55344

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 550	Continued From page 11 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support protection and safety by not posting the licensee's grievance procedure, with the current name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. This had the potential to affect all residents, staff, and visitors of the 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, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During a facility tour on May 26, 2026, at 11:13 a.m., the surveyor observed the facility postings and a grievance form located near the main entrance of the facility with licensed assisted living director (LALD)-A. The grievance form lacked contact information including the name, email, and phone number for the contact person for the individual responsible for handling resident grievances. On May 26, 2026, at 11:20 a.m., LALD-A stated the licensee was in the process of updating the required postings including the grievance procedure with the contact's name, number and email address. LALD-A then pulled a file from his office including the grievance procedure with required information. LALD-A verbalized he	0 550		

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0 550	Continued From page 12 planned to post the updated procedure. The licensee's Complaint / Grievance Posting policy dated July 28, 2022, indicated, "The community will post, in a conspicuous place, information about our complaint/grievance procedure, and the name, telephone number, and email contact information for the individual(s) who are responsible for handling resident complaint/grievances." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	0 660		

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0 660	Continued From page 13 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 TB history and symptom screening upon hire for one of three employees (unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee's Centers for Disease Control and Prevention Division of Tuberculosis Elimination Appendix B. Tuberculosis (TB) risk assessment worksheet, dated 2025, indicated the facility was at a low risk for TB transmission. ULP-D was hired November 1, 2025, to provide direct care for the residents. On June 1, 2026, from 12:23 p.m. to 12:55 p.m., the surveyor observed ULP-D and ULP-I assist R2 with a Hoyer (a mechanical lift) transfer from R2's Broda wheelchair (a specialized wheelchair to assist in positioning) to her bed. ULP-D's record included documentation of a negative TB serum test, dated May 11, 2025, greater than 90 days before hire, and lacked TB history and symptom screening completed upon hire.	0 660		

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0 660	Continued From page 14 On June 1, 2026, at 2:07 p.m., the surveyor provided, via email, the current Facility TB Risk Assessment Worksheet for Health Care Settings Licensed by Minnesota Department of Health (MDH) to be used by the licensee. On June 3, 2026, at 2:11 p.m., licensed assisted living director (LALD)-A stated the licensee did not have completed TB history and symptom screening documentation for ULP-D. The licensee's TB Prevention and Control policy dated May 20, 2022, indicated, "3. b. Upon hire all staff are screened for active signs of TB using the (Baseline TB Screening Tool) provided by the Minnesota Department of Health or a similar tool with all the required information." The CDC's Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel: Recommendations from the National Tuberculosis Controllers Association and CDC dated May 16, 2019, recommended all health care professionals complete a TB screening including a symptom evaluation and an IGRA or TST. Health care workers with written documentation of a previous positive TST or IGRA should have documented in their record: test results, assessment for current TB symptoms and a related chest x-ray. The MDH Regulations for TB Control in Minnesota Health Care Settings, dated July 2013, indicated baseline TB screening consists of three components: 1. Assessing for current symptoms of active TB disease, 2. Assessing TB history, and 3. Testing for the presence of infection with	0 660		

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0 660	Continued From page 15 Mycobacterium tuberculosis by administering either a two-step TST or single IGRA. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 690 SS=E	144G.43 Subdivision 1 Resident record (a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure entries in the resident records were current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry for two of three residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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:	0 690		

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0 690	Continued From page 16 Resident records were able to be edited to add information to documentation that was completed at an earlier date. R2 R2 was admitted on May 5, 2025, and had diagnoses which included Alzheimer's disease, and protein calorie insufficiency (malnutrition). On June 1, 2026, from 12:23 p.m. to 12:55 p.m., the surveyor observed R2's bedroom with unlicensed personnel (ULP)-D and ULP-I. R2's bed included bilateral "Halo"-style consumer bed rails in the upright position attached to a hospital style bed. ULP-D and ULP-I assisted R2 from the Broda wheelchair (a specialized wheelchair designed for advanced positioning support) to her bed using a Hoyer mechanical lift. R2's Quarterly assessment signed March 11, 2026, indicated on page six, "4. Assistive Device Assistance, notes included, "Resident can [no] longer walk, resident is now broader {sic} [Broda] wheelchair bound. need assist of one for locomotion, remind resident to ask for help as needed. Resident re-assessed for need of Halo bed assist rail due to impaired mobility and dependence on staff for bed mobility and transfers. Resident requires two-person assistance and use of a Hoyer lift for transfers. Resident is unable to independently transfer or ambulate. Quarterly Assessment completed, installation of Halo rail still intact. Purpose of device is to provide a stable handhold to assist with repositioning in bed and promote comfort during care. Resident assessed for cognitive status, safety awareness, and potential entrapment risks. Risks and benefits of Halo rail use reviewed with resident and/or responsible party, who verbalized understanding. Halo rail is	0 690		

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0 690	Continued From page 17 installed and inspected. Device securely attached according to manufacturer guidelines. Mattress fit evaluated with no gaps or entrapment hazards identified. Resident observed during care following installation. No signs of discomfort, injury, or unsafe interaction with the device noted. Resident will continue to require two-person assistance and Hoyer lift transfers; Halo rail is not to be used as a transfer device. Care plan updated to reflect use of Halo rail for bed mobility and positioning assistance. Staff instructed to monitor for changes in condition, skin integrity concerns, signs of entrapment, or other safety issues related to device use. Manufacturer instructions and recall information reviewed on 11 Mar. 2026, www.manualslib.com/manual/1558500/Halo-77301.html. No manufacturer recall notices identified at the time of review." It was later determined the documentation related to reviewing manufacturer instructions and recall notices was added to the assessment during the survey. R2's Care Plan dated March 10, 2026, indicated on page five, number 29, "Mobility: Bed Mobility Aide. As of: 03.11.2026 Resident re-assessed for need of Halo bed assist rail due to impaired mobility and dependence on staff for bed mobility and transfers." The care plan included the same remaining wording previously identified in the March 11, 2026, nursing assessment, including, "Manufacturer instructions and recall information reviewed on 11 Mar. 2026, www.manualslib.com/manual/1558500/Halo-77301.html. No manufacturer recall notices identified at the time of review." It was later determined the documentation related to reviewing manufacturer instructions and recall notices was added to the care plan during the	0 690		

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0 690	Continued From page 18 survey, and dated to indicate it was completed March 11, 2026. R3 R3 was admitted on October 31, 2024, and had diagnoses which included Alzheimer's disease and dysphagia (difficulty swallowing). On June 2, 2026, from 7:15 a.m. to 7:32 a.m., the surveyor observed R3's bedroom with ULP-H. R3's bed included bilateral "Halo"-type consumer bed rails in the upright position attached to a hospital-style bed. R3 was lying on her back in the bed. ULP-H assisted R3 from the bed with a transfer of one, to the wheelchair and into the bathroom to assist with personal cares. R3's Change of Condition assessment dated March 12, 2026, indicated on page six, "3. What type of assistive device does the resident utilize, if any?" "3/11/26 Put on Halo rails which were assessed for safety and brought in by family and is being placed on Hospice with hospital bed and bed table." On June 3, 2026, at 10:50 a.m., clinical nurse supervisor (CNS)-B provided an undated Care Plan for R3, which indicated "Care Plan for [R3] Last updated: 06/03/2026 by [CNS-B]", "Resident is WC bound and needs assistance. and now have {sic} Halo rails." Resident assessed for need of Halo bed assist rail related to impaired mobility and requirement for two-person assistance with transfers and bed mobility. Resident requires extensive assistance for repositioning and transfers in and out of bed. Halo rail recommended to provide a secure handhold for bed mobility and to promote safe transfers while maintaining resident comfort and safety. Prior to installation, resident evaluated for	0 690		

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0 690	Continued From page 19 cognitive status, mobility limitations, fall risk, and potential entrapment concerns. Benefits and potential risks of Halo rail use reviewed with resident and/or responsible party. Resident/responsible party voiced understanding. Halo rail installed and inspected. Device securely attached to bed frame per manufacturer guidelines. Mattress fit assessed with no significant gaps or entrapment hazards noted. Resident observed utilizing rail with staff assistance during bed mobility activities. No signs of distress, injury, or unsafe use observed. Care plan updated to reflect Halo rail use for assistance with bed mobility and transfers. Staff instructed to continue providing two-person assistance for transfers and to monitor for changes in condition, skin integrity issues, fall risk, and safe use of the device. Resident tolerated assessment and installation without incident." A portion of the assessment was dated to indicate it was completed March 11, 2026. R2 and R3's records were not permanently recorded, dated, and an authenticated with the name and title of the person making the entry. On June 3, 2026, at 1:34 p.m., when asked by the surveyor, CNS-B stated she added some bed rail assessment content to both R2 and R3's care plans, during the survey. On June 4, 2026, at 10:32 a.m., CNS-B stated, via phone, that during the survey, she added the last paragraph to R2's assessment and care plan which indicated, "Manufacturer instructions and recall information reviewed on 11 Mar. 2026, www.manualslib.com/manual/1558500/Halo-77301.html. No manufacturer recall notices identified at the time of review."	0 690		

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0 690	Continued From page 20 On June 4, 2026, at 1:45 p.m., during the exit conference, regional nurse (RN)-J stated the electronic medical record the licensee used should not have had the ability to be edited during the survey and an administrative setting must need to be corrected to ensure the residents record is permanent. RN-J verbalized, she planned to follow up and get the setting corrected. The licensee's Resident Records policy dated August 24, 2021, indicated, "Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry. Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure." No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	0 690		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota	0 775		

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0 775	Continued From page 21 Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated June 3, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
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) staff 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	0 810		

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0 810	Continued From page 22 evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff 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, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 810		

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0 810	Continued From page 23 Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated June 3, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by:	01440		

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01440	Continued From page 24 Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed direct supervision of staff performing delegated tasks within 30 calendar days after the date on which the individual began working for the facility and first performed the delegated task for one of two employees (unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee's employee roster indicated ULP-D was hired November 1, 2025, to provide direct care for the residents. On June 1, 2026, from 12:23 p.m. to 12:55 p.m., the surveyor observed ULP-D and ULP-I assist R2 with a Hoyer (a mechanical lift) transfer from R2's Broda wheelchair (a specialized wheelchair designed for positioning support) to her bed. ULP-D's employee record included a "Minnesota (MN) Direct Caregiver Orientation & Skills Checklist dated May 16, 2025, that indicated ULP-D demonstrated competency to the nurse with resident cares including transfers, personal cares, compression socks, vital signs, and mechanical lifts: Hoyer and EZ-Stand. ULP-D's record lacked evidence a RN completed	01440		

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01440	Continued From page 25 a 30-day supervision of a delegated nursing task. On June 3, 2026, at 8:50 a.m., clinical nurse supervisor (CNS)-B stated she would look to see if she could find a documented 30-day supervision of a delegated nursing task for ULP-D. On June 3, 2026, at 2:11 p.m., licensed assisted living director (LALD)-A stated the licensee was unable to find a 30-day supervision documented for ULP-D. The licensee's Supervision of Unlicensed Personnel policy dated August 24, 2021, indicated, "1. Supervision of Unlicensed Staff Performing Nursing or Delegated Nursing, Delegated Treatment or Assigned Therapy Services. a. Direct Supervision of Staff Providing Delegated Tasks. Direct supervision of unlicensed staff providing delegated nursing tasks, delegated treatments or assigned therapy tasks must be performed within 30 days after the person begins work for our agency and has been trained and determined competent to perform all the tasks assigned. The RN will directly supervise staff performing delegated nursing tasks and the appropriate licensed health professional will supervise unlicensed staff performing any delegated treatments or assigned therapies." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring	01620		

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01620	Continued From page 26 (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan 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. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) 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	01620		

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01620	Continued From page 27 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. (f) 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 observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted resident monitoring and reassessment including a reassessment completed within 14 days after the initiation of services for two of three residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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: On June 1, 2026, at 10:17 a.m., during the entrance conference, licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated the previous owner's nursing assessments were found in the Personal Service Plan for each resident.	01620		

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01620	Continued From page 28 R2 R2 was admitted May 5, 2025, and had diagnoses including Alzheimer's disease, asthma, and protein calorie insufficiency. R2's Individual Service Plan Agreement dated March 11, 2026, indicated R2 received services including assistance with housekeeping, laundry, meals, bathing, dressing, grooming, toileting, two-person mechanical lift transfers, and medication administration. On June 1, 2026, from 12:23 p.m. to 12:55 p.m., the surveyor observed unlicensed personnel (ULP)-D and ULP-I assist R2 with a Hoyer (a mechanical lift) transfer from R2's Broda wheelchair (a specialized wheelchair for positioning support) to her bed. R2's medical record included a Personal Service Plan (assessment) dated May 8, 2025, upon admission to the facility, and a subsequent assessment dated July 10, 2025, greater than 14 days (63 days) after start of services. R3 R3 was admitted October 31, 2024, and had diagnoses including Alzheimer's disease, Parkinson's, and dysphagia (difficulty swallowing). R3's Individual Service Plan dated February 27, 2026, indicated R3 received services including assistance with housekeeping, laundry, meals, bathing, dressing, grooming, toileting, transfers, and medication administration. On June 2, 2026, from 7:15 a.m. to 7:32 a.m., the surveyor observed ULP-H assist R3 with a one person transfer from R3's bed to wheelchair to R3's bathroom to assist with personal cares and	01620		

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01620	Continued From page 29 toileting for R3. R3's medical record included a Personal Service Plan (assessment) dated November 1, 2024, upon admission to the facility, and a subsequent assessment dated November 21, 2024, greater than 14 days (20 days) after start of services. On June 3, 2026, at 2:11 p.m., CNS-B stated R2 and R3's assessments were completed late. CNS-B verbalized she recently started employment with the licensee and was not sure why the 14-day assessments for R2 and R3 were not completed on time. The licensee's Nursing Assessment policy revised July 29, 2022, indicated, "5. A RN will complete the following comprehensive nursing assessments of the resident's physical, mental, and cognitive needs as required: a. Pre-Admission Assessment b. 14-day assessment: completed up to 14-days after start of services c. Ongoing assessment: completed periodically but no less than every 90-days d. Change in resident condition." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
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 service, according to the resident's current	01650		

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01650	Continued From page 30 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 resident service plan included the required content for three of three residents (R2, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large	01650		

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01650	Continued From page 31 portion or all of the residents). The findings include: R2 R2 was admitted May 5, 2025, and had diagnoses including Alzheimer's disease, asthma, and protein calorie insufficiency. R2's Individual Service Plan Agreement dated March 11, 2026, indicated R2 received services including assistance with housekeeping, laundry, meals, bathing, dressing, grooming, toileting, two-person mechanical lift transfers, and medication administration. On June 1, 2026, from 12:23 p.m. to 12:55 p.m., the surveyor observed ULP-D and ULP-I assist R2 with a Hoyer (a mechanical lift) transfer from R2's Broda wheelchair (a specialized wheelchair for positioning support) to her bed. R3 R3 was admitted October 31, 2024, and had diagnoses including Alzheimer's disease, Parkinson's, and dysphagia (difficulty swallowing). R3's Individual Service Plan dated February 27, 2026, indicated R3 received services including assistance with housekeeping, laundry, meals, bathing, dressing, grooming, toileting, transfers, and medication administration. On June 2, 2026, from 7:15 a.m. to 7:32 a.m., the surveyor observed ULP-H assist R3 with a one person transfer from R3's bed to wheelchair to R3's bathroom to assist with personal cares and toileting for R3. R4	01650		

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01650	Continued From page 32 R4 was admitted January 15, 2026, and had diagnoses including dementia and mood disturbance. R4's Individual Service Plan dated April 8, 2026, indicated R4 received services including assistance with housekeeping, laundry, meals, bathing, dressing, grooming, toileting, transfers, behavior management, and medication administration. R2, R3 and R4's service plans all lacked the following: -the methods of monitoring assessments of the resident; -the schedule and methods of monitoring staff providing services; and -a contingency plan that includes: -the action to be taken if the scheduled service cannot be provided; -information and a method to contact the facility; -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 -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. On June 3, 2026, at 8:25 a.m., licensed assisted living director (LALD)-A stated he was not aware the licensee's service plan did not include all the required content. LALD-A stated they completed new signed service plans using the licensee's	01650		

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01650	Continued From page 33 electronic medical record for all residents with the change in ownership. LALD-A stated he planned to review the information with the corporate team to ensure the licensee's service plans included all required content. The licensee's Service Plan Contents policy revised July 29, 2022, indicated, "5. Service plans will include: a. A description of the services provided b. Fees for services c. Frequency of each service according to resident assessment and resident preferences d. Identification of staff or categories of staff who will be providing services (RN, LPN, unlicensed personnel, etc.) e. Schedule and methods of monitoring assessments f. Schedule and methods of monitoring staff providing services g. Contingency plan h. A contingency plan that includes: i. Action taken if the scheduled service cannot be provided ii. Information and method to contact the community iii. Names and contact information of persons the resident wishes to have notified in an emergency iv. Names and contact information of persons the resident wishes to have notified if there is a significant adverse change in the resident's condition v. Identification of and information on who has authority to sign for the resident in an emergency vi. How the community will support documented resident health care directive decisions, if any-including circumstances in which emergency medical services are not to be	01650		

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01650	Continued From page 34 summoned." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01820 SS=E	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure there were current written or electronically recorded prescriptions as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility was managing for two of three residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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: R2	01820		

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01820	Continued From page 35 R2 was admitted May 5, 2025, and had diagnoses including Alzheimer's disease, asthma, and protein calorie insufficiency. R2's Individual Service Plan Agreement dated March 11, 2026, indicated R2 received services including assistance with housekeeping, laundry, meals, bathing, dressing, grooming, toileting, two-person mechanical lift transfers, and medication administration. On June 1, 2026, from 12:23 p.m. to 12:55 p.m., the surveyor observed ULP-D and ULP-I assist R2 with a Hoyer (a mechanical lift) transfer from R2's Broda wheelchair (a specialized wheelchair for advanced positioning support) to her bed. R2's medication administration record (MAR) for June 2026, indicated R2 was scheduled to take the following medications: -acetaminophen (for pain) 500 milligrams (mg), two caplets by mouth, three times daily; -Biofreeze (for pain) 4 percent (%) gel, apply to right knee and right hip, three times daily; -Deep Sea (for dry nose) 0.65% spray, instill one spray in each nostril, twice daily; -duloxetine (for depression) 60 mg, one capsule by mouth, daily; -gabapentin (for nerve pain) 300 mg, one capsule by mouth, daily; -latanoprost 0.005%, instill one drop in both eyes, daily at bedtime; -leflunomide (for arthritis) 20 mg, one tablet by mouth, once daily; -minerin cream (for dry skin), apply to skin topically, twice daily; -pantoprazole sodium (reduce stomach acid) film coated (f/c) 40 mg, one tablet by mouth, daily; -Senexon-S (for constipation) 8.6 mg - 50 mg, one tablet twice daily;	01820		

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01820	Continued From page 36 -Systane gel (for dry eyes) 0.3% - 0.4%, one drop in both eyes, four times daily; and -tramadol (for pain) 50 mg, one tablet by mouth, twice daily. R2's records lacked current signed provider orders for the above-listed medications. On June 3, 2026, at 1:23 p.m., clinical nurse supervisor (CNS)-B provided the surveyor with R2's signed provider orders, dated June 3, 2026 (completed during the survey). R3 R3 was admitted October 31, 2024, and had diagnoses including Alzheimer's disease, Parkinson's, and dysphagia (difficulty swallowing). R3's Individual Service Plan dated February 27, 2026, indicated R3 received services including assistance with housekeeping, laundry, meals, bathing, dressing, grooming, toileting, transfers, and medication administration. On June 2, 2026, from 7:15 a.m. to 7:32 a.m., the surveyor observed ULP-H assist R3 with a one person transfer from R3's bed to wheelchair to R3's bathroom to assist with personal cares and toileting for R3. R3's MAR for June 2026, indicated R3 was scheduled to take the following medications: -Baza Protect (a skin barrier cream) 1% - 12%, apply topically to buttocks, twice daily; -carbidopa-levodopa (for Parkinson's) 25 mg - 100 mg, one tablet by mouth, three times daily; -citalopram (for depression) 20 mg, one tablet by mouth daily; -clopidogrel 75 mg, one tablet by mouth daily; -folic acid (a supplement) 1 mg, one tablet by	01820		

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01820	Continued From page 37 mouth daily; -metoprolol tartrate (for high blood pressure) 25 mg, one half tablet by mouth daily; -tamsulosin hydrochloride (for urine retention) 0.4 mg, one capsule by mouth daily; -vitamin B-12 (a supplement) 1000 micrograms (mcg), one tablet by mouth daily; and -vitamin D3 (a supplement) 25 mcg, one tablet by mouth daily. R3's records lacked current signed provider orders for the above-listed medications. On June 2, 2026, at 2:32 p.m., CNS-B provided the surveyor with "Prescriber Authorization of Non-Controlled Medication Orders" for R3. The document lacked a signature and date. CNS-B stated she was not aware this document did not contain a date or signature of the provider. CNS-B verbalized R3's provider was at the facility that day, so they planned to get R3's orders signed. On June 3, 2026, at 12:59 p.m., CNS-B provided the surveyor with R3's signed provider orders, dated June 3, 2026 (completed during the survey). The licensee's undated Staff Assistance with Medications Policy indicated, "Staff will assist a Resident with administration of their medications when a Resident is having difficulty managing their own medications, or when the Resident requests assistance. Residents who need or request assistance with the administration of their medications, must have written orders from their physician for both prescription and over-the-counter medications. Whenever a Resident has a change in medication regime, the Resident or responsible party should notify the	01820		

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01820	Continued From page 38 Community staff and provide appropriate written authorization from their physician. Residents who are receiving assistance with the administration of their medications by Community staff must have all of their medication(s) centrally stored in a designated locked Community storage area that is not accessible to persons other than employees responsible for the supervision of centrally stored medications. All medications for Residents will be kept together but will be physically separated from other Residents' medications." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care must meet the requirements of section 144G.45 and the following additional requirements: (1) an assessment of safety risks must be performed on and around the property. The safety risks identified by the facility on the assessment must be mitigated to protect the residents from harm. The mitigation efforts must be documented in the facility's records; 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 observation, interview, and record	02040		

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 _____	06/04/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02040	Continued From page 39 review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated June 3, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and	02310	The licensee took appropriate action during the survey to mitigate the	

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	30691	A. BUILDING: _____ B. WING _____	06/04/2026

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02310	Continued From page 40 services according to acceptable health care standards, medical or nursing standards for two of two residents (R2, R3) who utilized consumer-style bed rails. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R3 R3 had diagnoses which included Alzheimer's disease and dysphagia (difficulty swallowing). On June 2, 2026, from 7:15 a.m. to 7:32 a.m., the surveyor observed R3's bedroom with unlicensed personnel (ULP)-H. R3's bed included bilateral "Halo"-type consumer bed rails in the upright position attached to a hospital-style bed. R3 was lying on her back in the bed. ULP-H assisted R3 from the bed with a transfer of one, to the wheelchair and into the bathroom to assist with personal cares. R3's Change of Condition assessment dated March 12, 2026, indicated on page six, "3. What type of assistive device does the resident utilize, if any?" "3/11/26 Put on Halo rails which were assessed for safety and brought in by family and is being placed on Hospice with hospital bed and bed table." On June 3, 2026, at 10:50 a.m., clinical nurse	02310	immediate risk to the residents. The scope and level remain the same.	

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	30691	A. BUILDING: _____ B. WING _____	06/04/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 41 supervisor (CNS)-B provided an undated Care Plan for R3, which indicated "Care Plan for [R3] Last updated: 06/03/2026 by [CNS-B]", "Resident is WC bound and needs assistance. and now have {sic} Halo rails." Resident assessed for need of Halo bed assist rail related to impaired mobility and requirement for two-person assistance with transfers and bed mobility. Resident requires extensive assistance for repositioning and transfers in and out of bed. Halo rail recommended to provide a secure handhold for bed mobility and to promote safe transfers while maintaining resident comfort and safety. Prior to installation, resident evaluated for cognitive status, mobility limitations, fall risk, and potential entrapment concerns. Benefits and potential risks of Halo rail use reviewed with resident and/or responsible party. Resident/responsible party voiced understanding. Halo rail installed and inspected. Device securely attached to bed frame per manufacturer guidelines. Mattress fit assessed with no significant gaps or entrapment hazards noted. Resident observed utilizing rail with staff assistance during bed mobility activities. No signs of distress, injury, or unsafe use observed. Care plan updated to reflect Halo rail use for assistance with bed mobility and transfers. Staff instructed to continue providing two-person assistance for transfers and to monitor for changes in condition, skin integrity issues, fall risk, and safe use of the device. Resident tolerated assessment and installation without incident." R3's record lacked: -evidence the licensee ensured the bed rails were not recalled by the Consumer Product Safety Commission (CPSC).	02310		

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 _____	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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
02310	Continued From page 42 On June 3, 2026, at 9:54 a.m., licensed assisted living director (LALD)-A provided the Halo manufacturer instructions. LALD-A provided a printed copy of the CPSC recall information and verbalized he reviewed the CPSC website "today" (June 3, 2026), during the survey. On June 3, 2026, at 10:49 a.m., CNS-B stated she was not aware the CPSC website was to be checked routinely and documented in the residents assessment or care plan to ensure no consumer-style bed rails were recalled. CNS-B verbalized she planned to do this going forward. R2 R2 had diagnoses which included Alzheimer's disease, and protein calorie insufficiency. On June 1, 2026, from 12:23 p.m. to 12:55 p.m., the surveyor observed R2's bedroom with ULP-D and ULP-I. R2's bed included bilateral "Halo"-style consumer bed rails in the upright position attached to a hospital style bed. ULP-D and ULP-I assisted R2 from the Broda wheelchair to her bed using a Hoyer mechanical lift. R2's Quarterly assessment signed March 11, 2026, indicated on page six, "4. Assistive Device Assistance, notes included, "Resident can [no] longer walk, resident is now broader {sic} [Broda] wheelchair bound. need assist of one for locomotion, remind resident to ask for help as needed. Resident re-assessed for need of Halo bed assist rail due to impaired mobility and dependence on staff for bed mobility and transfers. Resident requires two-person assistance and use of a Hoyer lift for transfers. Resident is unable to independently transfer or ambulate. Quarterly Assessment completed, installation of Halo rail still intact. Purpose of	02310		

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 _____	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02310	Continued From page 43 device is to provide a stable handhold to assist with repositioning in bed and promote comfort during care. Resident assessed for cognitive status, safety awareness, and potential entrapment risks. Risks and benefits of Halo rail use reviewed with resident and/or responsible party, who verbalized understanding. Halo rail is installed and inspected. Device securely attached according to manufacturer guidelines. Mattress fit evaluated with no gaps or entrapment hazards identified. Resident observed during care following installation. No signs of discomfort, injury, or unsafe interaction with the device noted. Resident will continue to require two-person assistance and Hoyer lift transfers; Halo rail is not to be used as a transfer device. Care plan updated to reflect use of Halo rail for bed mobility and positioning assistance. Staff instructed to monitor for changes in condition, skin integrity concerns, signs of entrapment, or other safety issues related to device use. Manufacturer instructions and recall information reviewed on 11 Mar. 2026, www.manualslib.com/manual/1558500/Halo-77301.html. No manufacturer recall notices identified at the time of review." It was later determined the documentation related to reviewing manufacturer instructions and recall notices was added to the assessment during the survey. R2's Care Plan dated March 10, 2026, indicated on page five, number 29, "Mobility: Bed Mobility Aide", noted "As of: 03.11.2026 Resident re-assessed for need of Halo bed assist rail due to impaired mobility and dependence on staff for bed mobility and transfers." The care plan included the same remaining wording previously identified in the March 11, 2026, nursing assessment, including, "Manufacturer instructions	02310		

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02310	Continued From page 44 and recall information reviewed on 11 Mar. 2026, www.manualslib.com/manual/1558500/Halo-77301.html. No manufacturer recall notices identified at the time of review." It was later determined the documentation related to reviewing manufacturer instructions and recall notices was added to the care plan during the survey. On June 3, 2026, at 1:34 p.m., when asked by the surveyor, CNS-B stated she added some bed rail assessment content to both R2 and R3's care plans, during the survey. On June 4, 2026, at 10:32 a.m., CNS-B stated, via phone, that during the survey, she added the last paragraph to R2's assessment and care plan which indicated, "Manufacturer instructions and recall information reviewed on 11 Mar. 2026, www.manualslib.com/manual/1558500/Halo-77301.html. No manufacturer recall notices identified at the time of review." After interviewing CNS-B, via phone, it was determined R2's record lacked: -evidence the licensee ensured the bed rails were not recalled by the Consumer Product Safety Commission (CPSC). The licensee's Supportive Devices policy revised January 20, 2026, indicated, "4. Side Rails: side rails are only allowed if the resident is cognitively intact and has an order from their provider stating the side rail is being used by the resident as a supportive device. Full side rails are not allowed. P-rails or a Halo is the preferred device over half side rails. Procedure, 1. An assessment must be completed by a licensed nurse (Supportive Device Assessment) prior to implementing any supportive device:	02310		

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02310	Continued From page 45 -A. The failure of the alternate methods will be documented on the assessment form. -B. If a supportive device is used, the least intrusive and most positive form of supportive device will be used. -C. A physician's order must be obtained. -D. The resident and/or resident's responsible party must approve of the supportive device. -E. When a supportive device is deemed necessary its use must be reviewed at every Care Conference and on any significant changes, with the goal of reduction and elimination. -F. The use of a supportive device must be documented on the resident's Service Plan. -G. The community will instruct caregivers on the correct use and precautions related to use of the device. -H. Resident will be educated and trained/in-serviced on how to safely use supportive device identified initially and on a routine basis. -I. Caregivers and licensed staff will be educated on the correct use and precautions related to use of the supportive device." Also, included, "2. Side Rails -A resident wishing to utilize side rails should meet the criteria above, and also have a PT consult to ensure that they are truly used for mobility purposes. -B. side rails must have approval of the regional nurse, and the corporate clinical risk department prior to implementing. -C. A copy of "Bed Rails for the Elderly" Article should be reviewed with and given to the responsible party. -D. Any bedside mobility device will need a Bedside Mobility Disclosure Form filled out and signed for the resident by the responsible party." The Food and Drug Administration (FDA)'s, A	02310		

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02310	Continued From page 46 Guide to Bed Safety, dated March 10, 2006, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients." The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQs), last updated December 12, 2024, indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment: - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's	02310		

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02310	Continued From page 47 guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements." In addition, "If a licensee is unable to locate manufacturer's guidelines, they are unable to assess and determine if the portable bed rail is being used appropriately and installed properly." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	02310		

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Brookdale Eden Prairie
7513 MITCHELL ROAD
Eden Prairie, MN 55344
Hennepin County
Parcel:

Phone:

License Info

License: HFID 30691

Risk:
License:
Expires on:
CFPM: Jessica Burns
CFPM #: 54598; Exp: 11/11/2027

Inspection Info

Report Number: F7994261118
Inspection Type: Full - Single
Date: 6/1/2026 Time: 1:27:58 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 1
Total Priority 3 Orders: 0
Delivery: Emailed

New Order: 4-300 Equipment Numbers and Capacities
4-302.13B *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.
COMMENT: Thermometer for testing the dishwasher was not found during inspection. Staff are working to procure a new one by the end of day.
Comply By: 6/1/2026 Originally Issued On: 6/1/2026

Food & Beverage General Comment

INSPECTION CONDUCTED IN THE PRESENCE OF HRD STAFF AND FINDINGS SHARED AT THE END OF INSPECTION.

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

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

TEMPERATURES:
Tomatoes 36
Watermelon 36

SANITIZERS:
Dishwasher 172

HRD INSPECTOR: Dede Hinnendael

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Metro District Office inspection report number F7994261118 from 6/1/2026

Jessica Burns

Crystal Elva, REHS, MS, BS
Public Health Sanitarian 3
651-201-3981
crystal.elva@state.mn.us

Minnesota (MDH) Version
EH Manager; RPT: F7994261118

Food Establishment Inspection Report

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

No. of Risk Factor/Intervention/Violations	0	Date: 6/1/2026
No. of Repeat Risk Factor/Intervention/Violations		Time: 1:27:58 PM
Score (optional)		Dur: min

Establishment:	Address:	City/State:	Zip:	Phone:
Brookdale Eden Prairie	7513 MITCHELL ROAD	Eden Prairie, MN	55344	
License/Permit #:	**Permit Holder:**	**Purpose of Inspection:**	**Est. Type:**	**Risk Category:**
HFID 30691		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Designated compliance status (IN, OUT, N/O, N/A) for each numbered item

IN=in compliance **OUT**=not in compliance **N/O**=not observed **N/A**=not applicable

Mark "X" in appropriate box for COS and/or R

COS=corrected on-site during inspection **R**=repeat violation

	Compliance Status		COS	R
	Supervision			
1	IN	Person in charge present, demonstrate knowledge and performs duties		
2	IN	Certified Food Protection Manager		
	Employee Health			
3	IN	knowledge, responsibiities, and reporting		
4	IN	Proper use of restriction and exclusion		
5	IN	Response to vomiting, diarrheal events		
	Good Hygienic Practices			
6	IN	Proper eating, tasting, drinking, tobacco use		
7	IN	No discharge from eyes, nose, and mouth		
	Preventing Contamination by Hands			
8	IN	Hands clean and properly washed		
9	IN	No bare hand contact with RTE foods, alternatives		
10	IN	Adequate handwashing sinks supplied and access		
	Approved Source			
11	IN	Food obtained from approved source		
12	N/O	Food Received at proper temperature		
13	IN	Food in good condition, safe & unadulterated		
14	N/A	Records available: shellstock tags, parasite dest.		
	Protection From Contamination			
15	IN	Food separated and protected		
16	IN	Food-contact surfaces; cleaned & sanitized		
17	IN	Proper Disposition of returned, previously served, reconditioned,& unsafe food		

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

Risk factors are improper practices or procedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health Interventions are control measures to prevent foodborne illness or injury

GOOD RETAIL PRACTICES

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

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

			COS	R
		Safe Food and Water		
30	IN	Pasteurized eggs used where required		
31		Water & ice from approved source		
32	N/A	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	N/O	Plant food properly cooked for hot holding		
35	IN	Approved thawing methods used		
36		Thermometers provided & accurate		
		Food Identification		
37		Food properly labeled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present; no unauthorized person		
39		Contamination prevented during food prep, storage, & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

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

Person in Charge (signature)

Inspector (signature) Crystal Elva

Follow-up: Follow-up Date:

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL30691016-0	**Date:** 6/3/2026
Facility Name: BROOKDALE EDEN PRAIRIE	
Facility Address: 7513 MITCHELL RD, EDEN PRAIRIE, MN 55344	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]

2. Fire doors shall be maintained to be self-closing and latch as designed. Fire doors shall not be blocked, obstructed, or otherwise made inoperable. [Minn. Stat. 144G.45 subd. 2; MSFC 705]

   Comments: The surveyor observed all resident units marked fire doors weren't equipped with self-closing hinges or devices that would close and latch the door from the open position.

3. Delayed egress locking systems shall: unlock upon activation of either the automatic sprinkler system or automatic fire detection system, unlock upon loss of power controlling the lock, have the capability of being unlocked from the fire command center and other approved locations. [Minn. Stat. 144G.45 subd. 2; MSFC 1010.1.9.8.1]

   Comments: The delayed egress system was not equipped with a separate de-activate switch or signal to unlock the system.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Twenty One (21) days

1. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include employee actions to be taken in the event of a fire or similar emergency. [Minn. Stat. 144G.45 subd.2]

   Comments: The FSEP failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate).

2. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include fire protection procedures necessary for residents. [Minn. Stat. 144G.45 subd.2]

   Comments: The FSEP did not identify specific fire protection actions for residents. There was no section in the plan that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency.

3. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include 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. [Minn. Stat. 144G.45 subd.2]

   Comments: The facility uses an electronic care plan website for standard resident evacuation procedures. The FSEP doesn't include standard resident evacuation procedures and failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents.

☒ **TAG IDENTIFICATION: 2040**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) days

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1. An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and have a safety risk assessment performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm. [Minn. Stat. 144G.81 subd.1]

   Comments: Surveyor requested the facility safety risk assessment, provided documentation was from a 3rd party vendor with general hazard vulnerability assessments with percentages assigned to each vulnerability. The assessment wasn't specific about the physical environment on or around the property, and it was missing mitigations to take when and if those hazards happened.