



*Protecting, Maintaining and Improving the Health of All Minnesotans*

December 14, 2021

Administrator  
Pioneer Estates  
8761 Preserve Boulevard  
Eden Prairie, MN 55344

RE: Project Number(s) SL32608015

Dear Administrator:

On December 8, 2021, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the September 30, 2021, evaluation were corrected. The follow-up evaluation verified that the facility is back in compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in cursive script, appearing to read 'Jessica Gallmeier'.

Jessica Gallmeier, Supervisor  
Health Regulation Division  
State Evaluation Team  
85 East Seventh Place, Suite 220  
P.O. Box 3879  
St. Paul, MN 55101-3879  
Email: [jess.gallmeier@state.mn.us](mailto:jess.gallmeier@state.mn.us)  
Phone: 651-247-0268 Fax: 651-215-9697

HHH



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered

October 26, 2021

Administrator  
Pioneer Estates  
8761 Preserve Boulevard  
Eden Prairie, MN 55344

RE: Project Number(s) SL32608015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on September 30, 2021, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

#### **IMPOSITION OF FINES**

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

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.

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

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

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

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

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

#### **DOCUMENTATION OF ACTION TO COMPLY**

Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order. A copy of the provider's records documenting those actions may be requested for follow-up surveys. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

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

#### **CORRECTION ORDER RECONSIDERATION PROCESS**

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days.

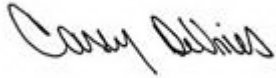
A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.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

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

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

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

Sincerely,



Casey DeVries, Supervisor  
Health Regulation Division  
State Evaluation Team  
85 East Seventh Place, Suite 220  
P.O. Box 3879  
St. Paul, MN 55101-3879  
Email: [casey.devries@state.mn.us](mailto:casey.devries@state.mn.us)  
Phone: 651-201-5917 Fax: 651-215-6894

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32608</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/30/2021</b>
--	--	---	---

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

(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	<p>Initial Comments</p> <p>Initial comments *****ATTENTION*****</p> <p>ASSISTED LIVING LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey</p> <p>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.</p> <p>INITIAL COMMENTS: SL32608015</p> <p>On September 28, through September 30, 2021, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 21 residents receiving services under the provider's Assisted Living License.</p>	0 000	<p>SL#32608015</p> <p>Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2 and 3</p>	
0 450 SS=C	<p>144G.41 Subdivision 1 Minimum requirements</p> <p>All assisted living facilities shall:</p>	0 450		

Minnesota Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32608</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/30/2021</b>
--	--	---	---

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

(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
0 450	<p>Continued From page 1</p> <p>(1) distribute to residents the assisted living bill of rights;</p> <p>(2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285;</p> <p>(3) utilize a person-centered planning and service delivery process;</p> <p>(4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285;</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide written acknowledgment for the current assisted living bill of rights (BOR) for three of three residents (R1, R2, R3) with records reviewed.</p> <p>This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>R1, R2, and R3's recorded lacked written acknowledgement for the current BOR released May 16, 2021.</p> <p>R1's record included old version of BOR signed by R1 March 24, 2021.</p>	0 450		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32608</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/30/2021</b>
--	--	---	---

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

(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
0 450	<p>Continued From page 2</p> <p>R2's record lacked written acknowledgement of receipt of current BOR.</p> <p>R3's record included old version of BOR signed by R3 March 24, 2021.</p> <p>On September 30, 2021, at approximately 11:00 a.m., registered nurse (RN)-A, Licensed Assisted Living Director (LALD)-C, and administrator (A)-D acknowledged BORs in resident records were not the current versions. A-D stated they did not know a newer version was released and only the older versions were included in all resident records. LALD-C stated they had the November 2019 version provided to all residents and they would need to update their acknowledgement form to ensure the current BOR version will be provided.</p> <p>The licensee's Resident Acknowledgement form dated February 14, 2018, indicated, "10. Minnesota Home Care of Rights Revised 11/19", an older version of the BOR would be provided to residents.</p> <p>No further information provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	0 450		
0 470 SS=F	<p>144G.41 Subdivision 1 Minimum requirements</p> <p>(11) develop and implement a staffing plan for determining its staffing level that:</p> <p>(i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility;</p> <p>(ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable</p>	0 470		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32608</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/30/2021</b>
--	--	---	---

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

(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
0 470	<p>Continued From page 3</p> <p>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;</p> <p>This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the required staffing plan was posted for residents, staff, and visitors to review as required. This had the potential to affect all 21 residents, staff, and visitors.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p>	0 470		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32608</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/30/2021</b>
--	--	---	---

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

(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
0 470	<p>Continued From page 4</p> <p>The findings include:</p> <p>The licensee lacked a posted daily staffing schedule developed by the clinical nurse supervisor to:</p> <ul style="list-style-type: none"> <li>- include direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked</li> <li>- identify the direct-care staff member's resident assignments or work location</li> <li>- 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</li> </ul> <p>On September 27, 2021, at 11:00 a.m., no posted staff schedule was observed in any area of the facility.</p> <p>On September 27, 2021, at approximately 11:30 a.m., the licensed assisted living director (LALD)-C confirmed no staffing schedule had been posted as required.</p> <p>The licensee lacked policies to include the new Assisted Living Licensure requirements, that went into effect August 1, 2021.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	0 470		
0 640	<p>144G.42 Subd. 7 Posting information for reporting suspected c</p> <p>The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and</p>	0 640		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32608</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/30/2021</b>
--	--	---	---

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

(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
0 640	<p>Continued From page 5</p> <p>suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language.</p> <p>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 information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) and failed to post the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect all 21 residents, staff, and visitors.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>The licensee lacked the following: - posting of 911 emergency number in common areas and near telephones provided by the Assisted Living facility - posting of information and the reporting number</p>	0 640		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32608</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/30/2021</b>
--	--	---	---

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

(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
0 640	<p>Continued From page 6</p> <p>for the MAARC to report suspected maltreatment of a vulnerable adult under section 626.557</p> <p>On September 27, 2021, at 11:00 a.m., during observation, the facility's main entry area and common areas lacked the required posted information.</p> <p>On September 27, 2021, at 11:30 a.m., the Licensed Assisted Living Director (LALD)-C confirmed the required content noted above had not been posted.</p> <p>The licensee lacked a policy related to posting of the adult abuse reporting and emergency numbers.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	0 640		
0 780 SS=E	<p>144G.45 Subd. 2 (a) (1) Fire protection and physical environment</p> <p>(a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:</p> <p>(1) for dwellings or sleeping units, as defined in the State Fire Code:</p> <ul style="list-style-type: none"> <li>(i) provide smoke alarms in each room used for sleeping purposes;</li> <li>(ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms;</li> <li>(iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics;</li> </ul>	0 780		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32608</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/30/2021</b>
--	--	---	---

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

(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
0 780	<p>Continued From page 7</p> <p>(iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and</p> <p>(v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;</p> <p>This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to maintain smoke alarms in four resident rooms and in one kitchen area. Unmaintained smoke detectors prevent early notification of a fire for the residents which can delay response time of evacuation of facility. This had the potential to directly affect all residents, staff, and visitors.</p> <p>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).</p> <p>The findings include: On September 29, 2021, between 9:40 a.m. and 2:30 p.m., survey staff toured the facility with maintenance director (M)-G. On September 29, 2021, at approximately between 10:40 a.m. to 12:30 p.m., the following were observed during the tour of the facility guided by M-G. The smoke alarm unit in bedroom 206 of Building</p>	0 780		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32608</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/30/2021</b>
--	--	---	---

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

(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
0 780	<p>Continued From page 8</p> <p>"P1" was opened and batteries were not installed. The smoke alarm in bedroom 208 of Building "P1" did not function when M-G tested the alarm. The smoke alarm in kitchen area of Building "P1" did not function when tested by the M-G. In addition, M-G opened the smoke alarm and the alarm was not connected with the cables inside the unit.</p> <p>The smoke alarm in bedroom 206 of Building "P2" did not function correctly when tested by M-G. In addition, M-G opened the smoke alarm and the alarm was not connected to the cables inside the unit.</p> <p>The smoke alarm in bedroom 207 of Building "P3" did not work when tested by M-G.</p> <p>On September 29, 2021, between 10:40 a.m. and 12:30 p.m., the M-G confirmed the compromised smoke alarms would be fixed. In addition, at 2:37 p.m., Licensed Assisted Living Director (LALD)-C acknowledged smoke alarm corrections would be made.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	0 780		
0 800 SS=D	<p>144G.45 Subd. 2 (a) (4) Fire protection and physical environment</p> <p>(4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.</p> <p>This MN Requirement is not met as evidenced by: Based on observation and interview, the facility</p>	0 800		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32608</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/30/2021</b>
--	--	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 800	<p>Continued From page 9</p> <p>failed to provide and maintain the building's physical environment including flooring, lighting, furnishing, etc in continuous state of good repair and operation for health, comfort, and well-being of residents in accordance with a maintenance and repair program. This had the potential to directly affect all residents and staff.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On September 29, 2021, between 10:30 a.m. and 12:20 p.m., survey staff toured the facility with maintenance director (M)-G and observed the following:</p> <p>Carpet in Room 207 of Building "P3" was heavily soiled and/or stained. M-G stated that there was no set schedule to clean carpet but rather, it was done on an as needed basis.</p> <p>Exhaust fans in half bathroom on main floor of Building "P3" and in half bathroom of Building P1 were significantly layered with dust. In addition, exhaust fan in resident shared bathroom 102/103 was missing a cover.</p> <p>The spring on the closet door of resident room 208 was broken and/or stuck. M-G attempted to fix the spring at time of tour.</p> <p>Portable fire extinguishers in all buildings lacked evidence of monthly inspection with recording on the tag to ensure location, access, and that it has not been tempered with. M-G was not aware of the monthly inspections required.</p>	0 800		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32608</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/30/2021</b>
--	--	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 800	<p>Continued From page 10</p> <p>Light bulbs in egress stairway of the lower level where laundry room connected in Building "P1" were burned out and not maintained. M-G acknowledged the bulbs were burned out and needed replacement.</p> <p>Doorknob to furnace room of Building "P1" fell off when grabbed to open.</p> <p>Door to resident room 101 of Building "P1" was not working correctly and had significant air gap opening at the top impeding on residential privacy. M-G stated that he flipped the door and was currently working on it.</p> <p>On September 29, 2021, between 10:30 a.m. and 12:20 p.m., M-G confirmed during tour interview that the above findings were in need of maintenance.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	0 800		
0 810 SS=F	<p>144G.45 Subd. 2 (b)-(f) Fire protection and physical environment</p> <p>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:</p> <ul style="list-style-type: none"> <li>(1) location and number of resident sleeping rooms;</li> <li>(2) employee actions to be taken in the event of a fire or similar emergency;</li> <li>(3) fire protection procedures necessary for residents; and</li> <li>(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</li> </ul>	0 810		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32608</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/30/2021</b>
--	--	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	<p>Continued From page 11</p> <p>evacuation.</p> <p>(c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter.</p> <p>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.</p> <p>(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.</p> <p>(f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to provide the required documentation on fire safety and evacuation plans, as well as required evacuation drills. In addition, the facility failed to provide documentation on staff and resident training, and training frequency related to evacuation. This had the potential to directly affect the safety of all residents and staff.</p> <p>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 had potential to affect a large portion or all of the residents).</p>	0 810		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32608</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/30/2021</b>
--	--	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	<p>Continued From page 12</p> <p>The findings include:</p> <p>On September 29, 2021, at approximately 9:45 a.m., survey staff requested facility fire safety and evacuation plan documentation for review including evacuation drills from administrator (A)-D. The A-D stated that the last fire evacuation drill was performed May (2021). At approximately 12:10 p.m., A-D provided documentation for review.</p> <p>The facility documentation provided failed to include the following:</p> <p>Fire protection procedures for residents. Identification of routes to nearest egress exit on the evacuation plan layout for each floor of each building. Each must be updated and posted for each floor of each building.</p> <p>Documentation of employee fire drills as required. The document indicated the last fire drill was performed on May 25, 2021. In addition, the facility fire drill policy section 7.05, dated March 28, 2017, page 1 of 2 incorrectly stated fire drills are not mandatory in Minnesota, and that a minimum of one evacuation drill was required every 6 months.</p> <p>The schedule and required records on training of employees on fire safety and evacuation.</p> <p>The schedule and required records on training of residents who are capable of assisting their own evacuation on proper actions to take in the event of a fire for their safety including movement, evacuation, or relocation.</p> <p>Employees and residents who are capable of assisting their own evacuation must be trained on fire safety and evacuation plans and procedures. Fire safety and evacuation plans must be readily</p>	0 810		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32608</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/30/2021</b>
--	--	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 13  available at all times within the facility. Employees are required to complete evacuation drills. Failure to provide these plans, training and drills can cause confusion and delay response time for evacuation of residents and employees.  On September 29, 2021, at 2:37 p.m., during an exit interview, the Licensed Assisted Living Director (LALD)-C acknowledged the provided information.  No further information was provided.  TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 900 SS=F	144G.50 Subdivision 1 Contract required  (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident.  (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable.  (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has	0 900		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32608</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/30/2021</b>
--	--	---	---

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

(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
0 900	<p>Continued From page 14</p> <p>been signed.</p> <p>(d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37.</p> <p>(e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3.</p> <p>(f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and execute a written contract with the required content for three of three residents (R1, R2, R3) with records reviewed.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>R1, R2, and R3's records lacked a written contract which included all of the terms concerning the provisions of the following as required:</p>	0 900		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32608</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/30/2021</b>
--	--	---	---

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

(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
0 900	<p>Continued From page 15</p> <p>(1) housing (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable</p> <p>In addition, R1, R2, and R3's records lacked evidence that the contract had been fully executed as the facility must:</p> <ul style="list-style-type: none"> <li>- offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract;</li> <li>- give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed; and</li> <li>- the facility must offer the resident the opportunity to identify a designated representative.</li> </ul> <p>On September 30, 2021, at approximately 11:00 a.m., registered nurse (RN)-A, Licensed Assisted Living Director (LALD)-C, and administrator (A)-D acknowledged current written contracts lacked all the required content. A-D stated the licensee knew the old contracts lacked specific required areas and a new contract had been developed and were in the process of presenting them to every resident to review and sign them. LALD-C stated they were working on getting the signatures on the new contracts but R1, R2, and R3's records would not include the new contract as they had not signed them.</p> <p>Licensee did not provide a policy related to developing, maintaining, and executing a written contract with the residents.</p> <p>No further information was provided.</p>	0 900		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32608</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/30/2021</b>
--	--	---	---

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

(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
0 900	Continued From page 16	0 900		
01530 SS=D	<p>144G.64 TRAINING IN DEMENTIA CARE REQUIRED</p> <p>(a) All assisted living facilities must meet the following training requirements:                      (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter;                      (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter;</p> <p>This MN Requirement is not met as evidenced by:                      Based on interview and record review the licensee failed to provide evidence of dementia care training on required topics for one of two</p>	01530		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32608</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/30/2021</b>
--	--	---	---

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

(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
01530	<p>Continued From page 17</p> <p>employees (RN-A), with records reviewed.</p> <p>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).</p> <p>The findings include:</p> <p>Registered Nurse (RN)-A's record lacked documentation of the required eight (8) hours of dementia training within 120 working hours of the employment start date.</p> <p>RN-A's hire date was August 3, 2021. Eight (8) hours of dementia training was required to have been completed by August 24, 2021.</p> <p>RN-A's record included one Certificate of Completion dated September 29, 2021, for A Comprehensive View of Alzheimer's Disease indicated training qualified for, "60 minutes of continuing education."</p> <p>On September 30, 2021, at approximately 11:00 a.m., RN-A stated s/he did not complete eight (8) hours of dementia training and had completed only one (1) hour since hire date. RN-A stated s/he worked 40 hours every week and provided direct care to the residents.</p> <p>The licensee's 3.01 Orientation for Home Care Staff policy dated March 28, 2017, identified dementia training was required, but lacked indicating required eight (8) hours of training to be</p>	01530		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32608</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/30/2021</b>
--	--	---	---

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

(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
01530	Continued From page 18  completed within 120 hours working hours of the employment start date.  No further information provided.  TIME PERIOD FOR CORRECTION: Fourteen (14) days	01530		
01620 SS=E	144G.70 Subd. 2 Initial reviews, assessments, and monitoring  (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.  This MN Requirement is not met as evidenced by: Based on interview and record review the	01620		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32608</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/30/2021</b>
--	--	---	---

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

(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
01620	<p>Continued From page 19</p> <p>licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment to include all areas identified on the uniform assessment tool for two of three residents (R1, R3) with records reviewed.</p> <p>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).</p> <p>The findings include:</p> <p>R1, and R3's records included assessments completed by registered nurse (RN)-A but lacked assessments in the required identified areas on the uniform assessment tool.</p> <p>R1's record included a one-page Pre &amp; Admission, 14/90 day, COC, Annual Assessment Tool form dated September 8, 2021, completed by RN-A and indicated as a 90-day assessment. Assessment lacked a full physical and cognitive assessment as required on the uniform assessment tool.</p> <p>R1 diagnosis included schizophrenia (disorder that affects a person's ability to think, feel, and behave clearly and symptoms can include delusions, hallucinations, disorganized speech, trouble with thinking and lack of motivation), end stage renal disease, hypertension, and hypertensive encephalopathy (decreased alertness, impaired cognitive function, delirium).</p>	01620		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32608</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/30/2021</b>
--	--	---	---

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

(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
01620	<p>Continued From page 20</p> <p>R1's service plan with effective date of September 28, 2021, indicated the services of bathing reminders, behavior management for anxiety, housekeeping, and medication administration.</p> <p>R3's record included a one-page Pre &amp; Admission, 14/90 day, COC, Annual Assessment Tool form dated September 17, 2021, completed by RN-A and indicated as a 90-day assessment. Assessment lacked a full physical and cognitive assessment as required on the uniform assessment tool.</p> <p>R3 diagnosis included multiple sclerosis (potentially disabling disease of the central nervous system), hypertension, bipolar disorder (mental health condition causing extreme mood swings), and seizures. R3's service plan with effective date of March 17, 2021, indicated the services of bathing assist, behavior management for anxiety, housekeeping, and medication administration.</p> <p>On September 30, 2021, at approximately 11:00 a.m., RN-A, Licensed Assisted Living Director (LALD)-C, and administrator (A)-D acknowledged the assessments lacked areas indicated on the uniform assessment tool. RN-A and A-D stated they were not aware of the uniform assessment tool requirements and that they were not included in any assessment for any resident.</p> <p>The licensee's 4.03 Assessment - Schedules policy dated March 28, 2017, lacked identification of uniform assessment tool areas to be completed during assessment, reassessment, and change of condition. Policy referenced statutes for 144A (Home Care) but should reference 144G (Assisted Living) that facility is</p>	01620		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32608</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/30/2021</b>
--	--	---	---

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

(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
01620	Continued From page 21 operated and licensed under.  No further information provided.  TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
01650 SS=E	144G.70 Subd. 4 Service plan, implementation, and revisions t  (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 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.	01650		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32608</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/30/2021</b>
--	--	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01650	<p>Continued From page 22</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included the required content for two of three residents (R1, R2) with records reviewed.</p> <p>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).</p> <p>The findings include:</p> <p>R1's signed service plan dated March 24, 2021, lacked identification of Med: Administration service.</p> <p>R1's Medication: Last Dose Given form indicated staff administered medications to R1 on September 28, 2021, at 9:25 a.m.</p> <p>On September 28, 2021, at approximately 9:30 a.m., R1 stated, "They [licensee] order, set up and deal with all my meds. I don't have to touch my meds."</p> <p>R2's service plan dated September 28, 2021, lacked the description and frequency of ordered supra-pubic catheter changes. R2's service plan also lacked the identification of staff or categories of staff who would provide the services. R2 had prescriber's orders dated, March 30, 2020, for "Change SPT foley Q 4 weeks and PRN, use 20</p>	01650		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32608</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/30/2021</b>
--	--	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01650	<p>Continued From page 23</p> <p>Fr. w/ 10 cc balloon antimicrobial foley".</p> <p>On September 30, 2021, at 9:15 a.m., RN-A stated the catheter changes were only done by licensed staff and the task was listed on the resident's medication/treatment list, however, verified the service description, frequency, and identification of staff to provide the service, was not listed on the resident's current service plan.</p> <p>On September 30, 2021, at approximately 11:00 a.m., RN-A, Licensed Assisted Living Director (LALD)-C, and administrator (A)-D acknowledged R1 and R2's service plans lacked required content. A-D stated they did not know why R1's signed contract did not indicate Med: Administration since the licensee had managed R1's medications since R1's admission.</p> <p>The licensee's Service Plans policy dated March 28, 2017, indicated all required content to be included in the service plans per 144G.70 subd. 4.</p> <p>No further information provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-One (21) days.</p>	01650		
01730 SS=D	<p>144G.71 Subd. 5 Individualized medication management plan</p> <p>(a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current</p>	01730		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32608</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/30/2021</b>
--	--	---	---

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

(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
01730	<p>Continued From page 24</p> <p>individualized medication management record for each resident based on the resident's assessment that must contain the following:</p> <ul style="list-style-type: none"> <li>(1) a statement describing the medication management services that will be provided;</li> <li>(2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions;</li> <li>(3) documentation of specific resident instructions relating to the administration of medications;</li> <li>(4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis;</li> <li>(5) identification of medication management tasks that may be delegated to unlicensed personnel;</li> <li>(6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and</li> <li>(7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions.</li> </ul> <p>(b) The medication management record must be current and updated when there are any changes.</p> <p>(c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop an individualized medication management record</p>	01730		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32608</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/30/2021</b>
--	--	---	---

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

(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
01730	<p>Continued From page 25</p> <p>with the required content for one of three residents (R1) with records reviewed.</p> <p>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).</p> <p>The findings include:</p> <p>R1's record lacked development and implementation of an individualized medication management record.</p> <p>R1's service plan dated September 28, 2021, indicated R1 received Med: Administration services effective May 29, 2020.</p> <p>R1's recorded included Medication Assessment Admission, Annual and Status Change form dated September 8, 2021, but lacked all required content for development and implementation of an individualized medication management record.</p> <p>On September 30, 2021, at approximately 11:00 a.m., RN-A, Licensed Assisted Living Director (LALD)-C, and administrator (A)-D acknowledged R1's record lacked development of an individualized medications management plan. RN-A stated they did not know why one was not included in their record as they create one for all residents receiving medication management. A-D acknowledged it must have been an oversight as it is required for all residents receiving medication management.</p>	01730		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>32608</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/30/2021</b>
--	--	---	---

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

(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
01730	<p>Continued From page 26</p> <p>The licensee's undated Individualized Medication Management Plan policy included all required content for developing and maintaining a current individualized medication management record for residents receiving medications management services according to Minnesota Statute 144G.71 subd. 5.</p> <p>No further information provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	01730		



Minnesota Department of Health  
Environmental Health, FPLS  
P.O. Box 64975  
St. Paul, MN 55164-0975  
651-201-4500

Type: Full  
Date: 09/28/21  
Time: 10:45:20  
Report: 1024211280

# Food and Beverage Establishment Inspection Report

**Location:**

PIONEER ESTATES  
8751 PRESERVE BLVD.  
EDEN PRAIRIE, MN55344  
Hennepin County, 27

**Establishment Info:**

ID #: N032608  
Risk:  
Announced Inspection: Yes

**License Categories:**

Expires on: 12/31/21

**Operator:**

Phone #:  
ID #:

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

The following orders were issued during this inspection.

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

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

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

OBSERVED RAW CHICKEN STORED ABOVE SPINACH IN P1 COOLER. OBSERVED BOXES OF SHELLED RAW EGGS ABOVE READY-TO-EAT FOODS IN ALL COOLERS. ADVISED TO REARRANGE.

Comply By: 09/28/21

**4-300 Equipment Numbers and Capacities**

**4-302.13B \*\* Priority 2 \*\***

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

NO IRREVERSIBLE THERMOMETER OR TEMPERATURE TEST STRIPS AVAILABLE ON SITE TO TEST IF UTENSIL SURFACE TEMPERATURE REACHES 160 dF. PROVIDE AND MAINTAIN.

Comply By: 09/28/21

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

**3-302.12**

MN Rule 4626.0240 Properly label all working containers holding food or food ingredients that are removed from original packages with the common name of the food. Label the food in English and any other languages used by employees who handle food.

OBSERVED UNLABELED CONTAINER OF BROWN SUBSTANCE ON KITCHEN COUNTER OF P1 HOUSE. CARETAKER ADVISED IT WAS BROWN SUGAR. ADVISED TO LABEL AND MAINTAIN.

Comply By: 09/28/21

Type: Full  
Date: 09/28/21  
Time: 10:45:20  
Report: 1024211280  
PIONEER ESTATES

# Food and Beverage Establishment Inspection Report

---

## 4-200 Equipment Design and Construction

### 4-201.11AMN

MN Rule 4626.0506A Provide or replace food service equipment with equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

DISHWASHING MACHINES IN P1 AND P3 HOUSES DO NOT HAVE "SANITIZE" OPTION. PROVIDE AND MAINTAIN.

*Comply By: 09/28/21*

## 4-300 Equipment Numbers and Capacities

### 4-303.11B

MN Rule 4626.0721B Provide chemical sanitizers to sanitize equipment and utensils during all hours of operation.

NO SANITIZER OBSERVED THROUGHOUT ESTABLISHMENTS. ADVISED TO PROVIDE AND MAINTAIN.

*Comply By: 09/28/21*

## 4-500 Equipment Maintenance and Operation

### 4-501.19CMN

MN Rule 4626.0780C Discontinue the use of a food preparation sink for anything other than food preparation.

OBSERVED TWO DIRTY MUGS IN FOOD PREPARATION SINK OF P3 HOUSE.

*Comply By: 09/28/21*

---

## Food and Equipment Temperatures

Process/Item: Ambient Temp

Temperature: 41 Degrees Fahrenheit - Location: P1 COOLER

Violation Issued: No

---

Process/Item: Ambient Temp

Temperature: 41 Degrees Fahrenheit - Location: P2 COOLER

Violation Issued: No

---

Process/Item: Ambient Temp

Temperature: 40 Degrees Fahrenheit - Location: P3 COOLER

Violation Issued: No

---

Total Orders	In This Report	Priority 1	Priority 2	Priority 3
		1	1	4

DISCUSSED ALL ORDERS ON SITE IN ADDITION TO THE FOLLOWING:

- PER CARETAKER, THERE ARE NO LEFT OVER FOODS. FOODS ARE COOKED FOR SAME-DAY SERVICE AND DISCARDED IF NOT CONSUMED.

Type: Full  
Date: 09/28/21  
Time: 10:45:20  
Report: 1024211280  
PIONEER ESTATES

# Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1024211280 of 09/28/21.

Certified Food Protection Manager: JAIMIE M. FAIRBANKS


Certification Number: FM100554 Expires: 07/26/22

**Inspection report reviewed with person in charge and emailed.**

Signed: \_\_\_\_\_

IRENE GAYE  
CARETAKER

Signed: \_\_\_\_\_

  
Sheng Yang  
Public Health Sanitarian I  
Freeman Building  
651-201-3985  
sheng.yang@state.mn.us