Electronically Delivered

November 21, 2024

Licensee
Living Hope Homes Eagles View
2904 Cooper Avenue South
Saint Cloud, MN 56301

RE: Project Number(s) SL39717015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on October 17, 2024, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

**STATE CORRECTION ORDERS**

The enclosed State Form documents the state correction orders. The Department of Health documents state 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 . . ."

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

**DOCUMENTATION OF ACTION TO COMPLY**

Per 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 residents/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 of the correction order receipt date.

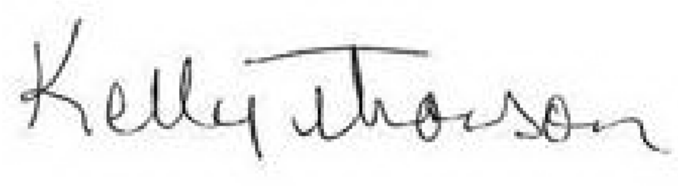
To submit a reconsideration request, please visit:
**https://forms.web.health.state.mn.us/form/HRDAppealsForm**

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,



Kelly Thorson, Supervisor
State Evaluation Team
Email: kelly.thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

JMD

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 39717 | A. BUILDING: _____ B. WING _____ | 10/17/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| LIVING HOPE HOMES EAGLES VIEW | 2904 COOPER AVENUE SOUTH SAINT CLOUD, MN 56301 |

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| 0 000 | Initial Comments<br><br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br><br>Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.<br><br>INITIAL COMMENTS:<br>SL39717015<br><br>On October 14, 2024, through October 17, 2024, 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 was six (6) residents receiving services under the Assisted Living license (provisional). | 0 000 | Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been 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 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.<br><br>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144A.474 SUBDIVISION 11 (b)(1)(2). | |
| 0 480 SS=F | 144G.41 Subd 1 (13) (i) (B) Minimum requirements | 0 480 | | |

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| 0 480 | Continued From page 1<br><br>(13) offer to provide or make available at least the following services to residents:<br>(B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).<br>The findings include:<br><br>Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated October 14, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.<br><br>TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates. | 0 480 | | |
| 0 800 SS=E | 144G.45 Subd. 2 (a) (4) Fire protection and physical environment<br><br>(4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of | 0 800 | | |

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| 0 800 | Continued From page 2<br><br>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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect a limited number of residents, staff, and visitors.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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).<br><br>The findings include:<br><br>On October 16, 2024, at 10:15 a.m., survey staff toured the facility with licensed assisted living director (LALD)-A. During the tour, the surveyor observed the following:<br>- The escutcheon for the fire sprinkler head was missing in occupied resident room 1. An escutcheon is necessary to ensure the sprinkler head will activate properly in the event of a fire.<br>- An extension cord was used to supply power to the refrigerator in the med room.<br>- Extension cords were used to supply power in occupied resident rooms 4 and 6. | 0 800 | | |

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| 0 800 | Continued From page 3<br><br>Improper use of extension cords creates a fire hazard.<br>- There were holes in the wall behind the front door of the facility and in resident room 6.<br><br>During the facility tour interview on October 16, 2024, LALD-A verified the above listed observations.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 800 | | |
| 0 810 SS=F | 144G.45 Subd. 2 (b)-(f) Fire protection and physical environment<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms;<br>(2) employee actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for residents; and<br>(4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation.<br>(c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter.<br>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.<br>(e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The | 0 810 | | |

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| 0 810 | Continued From page 4<br><br>training shall be made available to residents at least once per year.<br>(f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to develop a fire safety and evacuation plan with the required content and provide required drills. This had the potential to directly affect all residents, staff, and visitors.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>On October 16, 2024, at 10:15 a.m., survey staff toured the facility with licensed assisted living director (LALD)-A. During the tour, LALD-A verbally identified resident sleeping room 3. The surveyor observed a number was not posted on or adjacent to the door for this resident sleeping room. LALD-A stated the resident had removed the room identifier from the door and verified this sleeping room was not properly identified.<br><br>During the tour, the surveyor observed resident | 0 810 | | |

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| 0 810 | Continued From page 5<br><br>sleeping room numbers posted on the doors did not match the number labels on the posted FSEP floor plan. Resident sleeping room identifiers must correspond with the labels on the fire safety and evacuation floor plan to provide efficient communication for exiting in the event of a fire or similar emergency. During the facility tour interview on October 16, 2024, LALD-A verified the FSEP floor plan did not accurately identify the resident sleeping rooms.<br><br>On October 16, 2024, LALD-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility.<br><br>FIRE SAFETY AND EVACUATION PLAN<br>The licensee failed to develop and maintain a FSEP evident by a record review of the available documentation. The FSEP included a 4.7 Fire Safety policy dated August 1, 2021. This fire safety policy was a template from a third-party provider and not developed for use at this facility location.<br><br>The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The FSEP fire safety policy inappropriately referenced smoke compartment doors, doors on magnetic holders, and a fire alarm system wired to the fire department.<br><br>The FSEP fire safety policy did not identify specific fire protection procedures necessary for residents evident by a lack of these procedures in the plan. | 0 810 | | |

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| 0 810 | Continued From page 6<br><br>The licensee failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents in the FSEP. Two residents were identified with an evacuation level status that required assistance in an evacuation and no procedures were included in the FSEP.<br><br>During an interview on October 16, 2024, at 11:10 a.m., LALD-A verified the FSEP required revision.<br><br>DRILLS<br>Record review of the available documentation indicated the licensee did not conduct employee evacuation drills every other month evident by a review of completed drill logs lacking the required frequency. Provided documentation indicated drills were conducted on 3/20/24, 5/14/24, 8/9/24, and 9/28/24, with no additional drills documented for the year. During an interview on October 16, 2024, at 11:10 a.m., LALD-A verified the licensee had not conducted evacuation drills at the frequency required by statute. Record review of the available documentation indicated the licensee did not include the last names of the employees who participated on all of the fire drill logs. During an interview on October 16, 2024, at 11:10 a.m., LALD-A verified the fire drill logs lacked the required information.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 810 | | |
| 01060 SS=D | 144G.52 Subd. 9 Emergency relocation<br><br>(a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent | 01060 | | |

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| 01060 | Continued From page 7<br>risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination.<br>(b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum:<br>(1) the reason for the relocation;<br>(2) the name and contact information for the location to which the resident has been relocated and any new service provider;<br>(3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities;<br>(4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and<br>(5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal.<br>(c) The notice required under paragraph (b) must be delivered as soon as practicable to:<br>(1) the resident, legal representative, and designated representative;<br>(2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and<br>(3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days.<br>(d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and | 01060 | | |

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| 01060 | Continued From page 8<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation for one of one resident (R1).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).<br><br>The findings include:<br><br>R1 was admitted on May 3,2023.<br><br>R1's diagnoses included a type 2 diabetes.<br><br>R1's Service Plan dated April 17, 2024, indicated R1 received services including medication assistance, blood sugar monitoring, and oxygen maintenance.<br><br>R1's progress note dated April 12, 2024, noted R1 was admitted to the hospital. R1's progress dated April 15, 2024, noted resident was diagnosed with pneumonia and returned back to the facility.<br><br>R1's record lacked a written notice that contained, at a minimum:<br>- the reason for the relocation;<br>- the name and contact information for the location to which the resident has been relocated | 01060 | | |

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| 01060 | Continued From page 9<br><br>and any new service provider;<br>- contact information for the OOLTC;<br>- if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and<br>- a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal.<br><br>October 15, 2024, at 9:18 a.m., clinical nurse supervisor (CNS)-D stated "we were not aware that this was a requirement until June when we had another survey."<br><br>Licensee's 1.23 Emergency Relocation policy dated August 1, 2021, read in the vent of an emergency relocation, licensee would provide a written notice that contained at minimum:<br>-a reason for the relocation;<br>-the name and contact information for the location to which the resident had been relocated and any new services;<br>-contact information for the office of ombudsman for long-term care;<br>-if applicable the approximate date or range of dates within which the resident would return to facility; and<br>-a statement that if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 01060 | | |

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| 01500 | Continued From page 10 | 01500 | | |
| 01500 SS=D | 144G.63 Subd. 5 Required annual training<br><br>(a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include:<br>(1) training on reporting of maltreatment of vulnerable adults under section 626.557;<br>(2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;<br>(3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases;<br>(4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders;<br>(5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and<br>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.<br>(b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. | 01500 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 39717 | A. BUILDING: _____ B. WING _____ | 10/17/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LIVING HOPE HOMES EAGLES VIEW | 2904 COOPER AVENUE SOUTH SAINT CLOUD, MN 56301 |

| (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 |
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| 01500 | Continued From page 11<br><br>Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:<br>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication;<br>(2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or<br>(3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure employees received at least eight (8) hours of training for each 12 months of employment for one of one employee (unlicensed personnel (ULP)-C).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).<br><br>The findings include:<br><br>ULP-C was hired on June 21, 2022, to provide | 01500 | | |

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| 01500 | Continued From page 12<br>direct care services to residents.<br><br>ULP-C's employee record lacked the following required annual training:<br>-principles pf person-centered planning/services delivery.<br><br>ULP-C's My Transcript (educational transcript) noted ULP-C completed principles of person-centered planning/delivery dated July 11, 2022.<br><br>On October 17, 2024, at 9:14 a.m., LALD-A stated "I was not aware that was an annual requirment."<br><br>The licensee's 5.06 Annual Required Staff Training policy dated August 1, 2021, read the following elements must be included every 12 months to all staff who perform direct care services:<br>-principles of person-centered planning and service delivery.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01500 | | |
| 01890 SS=E | 144G.71 Subd. 20 Prescription drugs<br><br>A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. | 01890 | | |

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| 01890 | Continued From page 13<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure medications dispensed by the pharmacy included a prescription label and were labeled with open and expiration dates for time sensitive medications, and discard expired medication for five of six residents (R1, R2, R3, R4, R5).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a 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).<br><br>The findings include:<br><br>On October 14, 2024, at 10:45 a.m. surveyor, licensed assisted living director (LALD)-A and licensed practical nurse (LPN)-B observed the overflow medication cabinet and the medication cart and found the following:<br><br>Expired medication:<br>R1<br>-oxymetazoline with an expiration date of May 5, 2023;<br>-humalog insulin pen with an expiration date of September 27, 2024; and<br>-ventolin hfa aer inhaler with an expiration date of January 21, 2024.<br><br>R2<br>-culturelle with an expiration date of October 6, | 01890 | | |

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| 01890 | Continued From page 14<br><br>2024; and<br>- polyethylene with an expiration date of May 30, 2023.<br><br>R3<br>-capsaicin cream with an expiration date of April 6, 2024.<br><br>R5<br>-ventolin hfa aer inhaler with an expiration date of January 21, 2024.<br><br>No label:<br>R4<br>-tylenol 500 milligrams (mg) bottle with no name labeled; and<br>- antacid bottle with no name labeled.<br><br>No open date on time sensitive medication:<br>R1<br>-lantus insulin pen<br>-humalog insulin pen<br><br>On October 14, 2024, at 11:04 a.m. LPN-B stated she had oversight of auditing the medications and discarding expired medications monthly. LPN-B stated employees would follow a dated medications to expire list next to the medication cart and would label the medications according to the list.<br><br>On October 14, 2024, at 12:10 p.m. surveyor observed unlicensed personnel (ULP)-C administer R1's afternoon medications. ULP-C obtained R1's insulin pens from the medication cart. Observed a used insulin pen Humulog and a used insulin pen Lantus that lacked an open date on each pen. At this time, ULP-C stated, "we usually place the open dates on the pens." ULP-C continued to provide R1 the insulin pen to inject | 01890 | | |

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| 01890 | Continued From page 15<br>her medication.<br><br>On October 14, 2024, at 12:18 p.m. clinical nurse supervisor (CNS)-D and LPN-B noted staff are trained to place dates on time-sensitive medications.<br><br>The licensee's 7.11 Medications and Treatments policy dated August 1, 2021, read medications would be stored consistent with each resident's medication plan and services and time sensitive medications would be dated with open dates and expirations dates.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01890 | | |
| 02310 SS=F | 144G.91 Subd. 4 (a) Appropriate care and services<br><br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure medical oxygen tanks secured stored properly in noncombustible racks to prevent injury to all residents who resided in the assisted living facility.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or | 02310 | | |

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| 02310 | Continued From page 16<br><br>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 widespread scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).<br><br>The findings include:<br><br>On October 16, 2024, at 10:30 a.m., in R1's room, were three oxygen cylinders unsecured upright position on resident's floor. The oxygen cylinders were not secured with a rack or chain.<br><br>On October 17, at 9:02 a.m., licensed practical nurse (LPN)-B and clinical nurse supervisor (CNS)-D stated when resident returns from an outing she does not notify staff and does not like staff entering her room to obtain the oxygen cylinders to place the cylinders back in the rack in the med room.<br><br>The licensee's 7.40 Oxygen policy dated August 1, 2021, read oxygen cylinders and vessels must remain upright at all times in a well-ventilated area.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 02310 | | |

Minnesota Department of Health
Environmental Health Division
3333 W. Division #212
St. Cloud
320-223-7300

Type: Full
Date: *10/14/24*
Time: 11:15:43
Report: 1041241237

# Food and Beverage Establishment Inspection Report



**Location:**
Living Hope Homes-Eagles View
2904 Cooper Ave South
St Cloud, MN56301
Stearns County, 73

**Establishment Info:**
ID #: 0043764
Risk:
Announced Inspection: No

**License Categories:**

Expires on: / /

**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.

**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.

THE INSTAPOT AIR FRYER, RIVA WAFFLE MAKER, RICE COOKER, NOSTALGIA WAFFLE MAKER, AND GRIDDLE ARE NOT APPROVED. REMOVE AND REPLACE WITH ANSI CERTIFIED EQUIPMENT.

*Comply By: 10/30/24*

**Surface and Equipment Sanitizers**

Hot Water: = at 174 Degrees Fahrenheit
Location: DISHWASHER FINAL RINSE CYCLE
Violation Issued: No

**Food and Equipment Temperatures**

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: MILK
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 42 Degrees Fahrenheit - Location: BOLOGNA
Violation Issued: No

Type: Full
Date: *10/14/24*
Time: 11:15:43
Report: 1041241237
Living Hope Homes-Eagles View

# Food and Beverage Establishment Inspection Report

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

**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 1041241237 of 10/14/24.

Certified Food Protection Manager NANCY SIMMONS

Certification Number: 107295 Expires: 08/13/27

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

Signed: _____
Establishment Representative

Signed: Linda Heinen

Linda Heinen
Public Health Sanitarian
St. Cloud
320-223-7306
Linda.Heinen@state.mn.us