Electronically Delivered

November 7, 2024

Licensee
Eagle Group Home LLC
6400 Noble Avenue North
Brooklyn Center, MN 55429

RE: Project Number(s) SL36304015

Dear Licensee:

On September 19, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the July 24, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Benjamin J. Zwart, P.E., Supervisor
State Engineering Services Section
Email: Benjamin.Zwart@state.mn.us
Telephone: 651-201-3715 Fax: 1-866-890-9290

HHH

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August 30, 2024

Licensee
Eagle Group Home LLC
6400 Noble Avenue North
Brooklyn Center, MN 55429

RE: Project Number(s) SL36304015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 24, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

The correction order documentation should include the following:

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

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

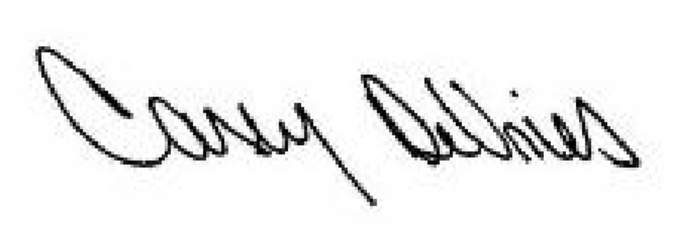
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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,



Casey DeVries, Supervisor
State Evaluation Team
Email: 651-201-5917
Telephone: 651-201-5917 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36304	A. BUILDING: _____ B. WING _____	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE GROUP HOME LLC	6400 NOBLE AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL36304015-0 On July 22, 2024, through July 24, 2024, the Minnesota Department of Health conducted an Assisted Living license survey at the above provider, and the following correction orders are issued. At the time of the survey, there was one resident living at the facility; one receiving services under the Assisted Living license.	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/Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144A.474 subd. 11 (b) (1) (2) -or- 144G.31 subd. 1, 2 and 3	
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 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This had the potential to affect all residents of the assisted living facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated July 23, 2024, for the specific Minnesota Food Code deficiencies. The Inspection Report was provided to the licensee on July 24, 2024. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 570 SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at	0 570		

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0 570	Continued From page 2 the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to display the original current license at the main entrance of the assisted living facility as required. This had the potential to affect all residents, staff, and visitors. 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). The findings include: The licensee held an assisted living license effective January 1, 2024, with an expiration date of December 31, 2024. On July 22, 2024, at 10:06 a.m., during the facility tour with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A and administrator (A)-C, the surveyor observed the licensee had posted a copy of their current assisted living license, with the above dates, on a bulletin board in the facility living room. The original license was not posted as required. LALD/CNS-A and A-C stated they thought they could post a copy of the license. On July 23, 2024, at 11:40 a.m., the surveyor observed the original license posted in place of	0 570		

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0 570	Continued From page 3 the copied license the day before. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 570		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	0 680		

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0 680	Continued From page 4 review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required content and to post it prominently in a conspicuous place for staff, residents, and visitors to view. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 22, 2024, at 10:44 a.m., the surveyor inquired where the EPP was located. Administrator (A)-C stated it was located in a drawer of the filing cabinet in the office space of the living room. A-C stated they did not have any signage posted to direct staff, residents, or visitors to the EPP. A-C took the EPP out of the drawer and put it on top of the filing cabinet to have it displayed prominently. On July 23, 2024, the licensee's Emergency Preparedness Plan last updated on May 14, 2024, was reviewed by the surveyor, and lacked the following required information: -Evidence the licensee developed strategies for addressing facility & community-based risks (i.e.: transportation); -Evidence the licensee developed and implemented EP policies and procedures (P/P) to address the following whether evacuated or shelter in place for staff/residents: -Food, water, medical supplies,	0 680		

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0 680	Continued From page 5 pharmaceutical supplies -Evidence of P/P for at minimum food, water, and pharmaceutical supplies; -Evidence EP included P/P related to sewage/waste disposal; -Evidence the licensee developed P/P for system to track the location of on-duty staff and sheltered residents; -Evidence the licensee developed P/P to address: use of volunteers, including the process/role for integration; and -Evidence the licensee developed P/P to address the role of the licensee under a waiver declared by the Secretary in accordance with section 1135 of the Act. On July 23, 2024, at 11:27 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they planned to use a van that they had on standby with another facility for transportation but stated it was not documented in their EPP. LALD/CNS-A stated shelter in place supplies were not identified in their EPP. LALD/CNS-A stated their shelter in place supplies were stored at a, "central location," approximately 15 minutes away from the facility and stated they understood why offsite storage would be problematic in the event of a shelter in place situation. LALD/CNS-A stated waiver 1135 was not addressed in their EPP. LALD/CNS-A and administrator (A)-C did not know what waiver 1135 was. LALD/CNS-A stated volunteers were not addressed in the EPP. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated: " [Licensee] will have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services.	0 680		

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0 680	Continued From page 6 The plan considers the organization's commitment to provide services while ensuring the safety of its employees and residents. [Licensee] will implement the Emergency Management program* as soon as the agency becomes aware of the existence of an emergency." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of the residents, visitors, and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 800		

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0 800	Continued From page 7 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 24, 2024, from approximately, 10:00 a.m. to 11:00 a.m., survey staff toured the home with the administrator (A)-C and the licensed assisted living director/clinical nurse supervisor (LALD/CMS)-A. During the home tour, survey staff observed the following: -The licensee lacked maintenance for proper roof drainage to protect the home. Small plants and garden weeds were observed on the perimeter of the roof gutter system around the house indicating the gutter had not been cleaned out and full of dirt/debris for plants to grow. The LALD/CMS-A and the A-C verified the finding and they agreed they could not remember when the last time the roof gutter system had been cleaned out. -The furnace filter was filled with thick dirt. When asked about the frequency of filter cleaning, the LALD/CMS-A and the A-C could not remember the last time the filter was replaced. -The stair handrail from the main-level floor to the basement was loose and not secured for safe use. -Improper disposal of cigarette butts in a metal can and inside a plastic bottle located inside the one-car garage. Survey staff asked about the home's designated smoking area and a proper cigarette butt receptacle. The LALD/CMS-A verified the finding and stated that their designated area of smoking is in the back of the house where they have provided a cigarette butt receptor for proper disposal.	0 800		

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0 800	Continued From page 8 During an interview, survey staff explained the above deficient conditions to the LALD/CMS-A and the A-C, and they understood and acknowledged the findings at the time of discovery during the home tour. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 820 SS=F	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide the minimum state standard-sized egress windows for occupied resident sleeping room 2 and unoccupied resident rooms 1 and 3. This has the potential to	0 820		

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0 820	Continued From page 9 directly affect the health, safety, and well-being of the residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 24, 2024, from approximately, 10:00 a.m. to 11:00 a.m., survey staff toured the home with the administrator (A)-C and the licensed assisted living director/clinical nurse supervisor (LALD/CMS)-A. During the home tour, survey staff observed the following: OCCUPIED RESIDENT ROOM 2 Inside the occupied main-level resident sleeping room 2, survey staff measured the clear openings of the two double-hung windows, neither window met the state standard-sized window requirement for safe egress in sleeping room with the minimum width and height of no less than 20 inches of clear opening and a minimum total open area of 648 inches for safe egress. The largest window in sleeping room 2 measured dimensions, height at 18.75 inches, and width at 31 inches, totaling a clear opening area of 620 square inches. Survey staff explained to the LALD/CMS-A and the A-C that at least one of the two windows in room 2 must have the required state standard-sized window in each sleeping room with a minimum width and height of no less than 20 inches of clear opening, and a minimum	0 820		

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0 820	Continued From page 10 total open area of 648 inches required for safe egress. The above finding was verbally verified with the LALD/CMS-A and the A-C at the time of discovery accompanying the home tour. TIME PERIOD FOR CORRECTION: Two (2) days UNOCCUPIED RESIDENT ROOMS 1 and 3 Inside the unoccupied main-level resident sleeping rooms 1 and 3, survey staff measured the clear openings of the double-hung windows. Both sleeping room windows failed to have at least one state standard-sized window in each room with a minimum width and height of no less than 20 inches of clear opening and a minimum total open area of 648 inches required for safe egress. The largest window in rooms 1 and 3 measured dimensions, height at 13.5 inches, and width at 31 inches, totaling a clear opening area of 418.5 square inches for each window. Survey staff explained to the LALD/CMS-A and the A-C that at least one window in each sleeping room must have the required state-standard minimum width and height of no less than 20 inches of clear opening and a minimum total area of 648 inches (4.5 square feet) for existing sleeping rooms in assisted living homes. The above deficient findings were verbally verified with the LALD/CMS-A and the A-C at the time of discovery accompanying the home tour. TIME PERIOD FOR CORRECTION: Seven (7) days On July 24, 2024, at approximately 11:30 a.m., during the interview, survey staff explained to the	0 820		

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0 820	Continued From page 11 LALD/CMS-A and the A-C about the above deficient findings on egress windows during the home tour. Immediately, the LALD/CMS-A and the A-C provided documentation for review, Correction Plan for Egress Windows, undated but had an effective date of July 21, 2024, an hourly fire watch log from July 21, 2024, to date (July 24, 2024) to 11 a.m., and an egress window replacement price quote with an order dated, July 23, 2024. The LALD/CMS-A and the A-C further explained that they recently found out about the deficient condition of the egress window of occupied room 2 and have implemented a plan of corrections and a continuous fire watch to ensure the resident in room 2 is safe as well as providing a price quote to replace the window in sleeping room 2. For sleeping rooms 1 and 3, the LALD/CMS-A and the A-C stated that they had not received a price quote yet since the rooms were not occupied. Survey staff explained to the LALD/CMS-A and the A-C that sleeping rooms 1 and 3 must not be occupied until the deficient conditions are corrected with the complying egress window in each, and the plan of correction and the fire watch for bedroom 2 must be maintained until the approved egress window is replaced. The LALD/CMS-A and the A-C understood and acknowledged the above findings. No further information was provided.	0 820		
01750 SS=F	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the	01750		

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	36304	A. BUILDING: _____ B. WING _____	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01750	Continued From page 12 proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medication orders did not require unlicensed personnel (ULP) to make medication dosage decisions, which was outside of their scope of practice, for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 was admitted to the licensee on July 26, 2023. R2's Service Plan dated July 27, 2023, indicated R2 received services for housekeeping, medication administration, meal reminder, dressing, and bathing assistance. R2's Medication & Treatment Orders form dated March 25, 2024, signed by a prescriber, indicated R2 was prescribed the following medications:	01750		

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01750	Continued From page 13 -ibuprofen 600 milligram (mg) tablet, take PO (by mouth) PRN (as needed); -quetiapine 200mg tablet, take PO daily. R2's After Visit Summary (AVS) dated March 25, 2024, unsigned by a prescriber, indicated R2 was prescribed the following medications: -ibuprofen 600mg tablet, take one to two tablets (600mg-1,200mg) PO PRN; -quetiapine 100mg tablet, take two tablets (200mg) PO two times a daily. R2's Med Admin Summary (medication administration record (MAR)) for July 2024, indicated R2 took: -ibuprofen 600mg tablet, take one to two tablets PO PRN for moderate pain; and -quetiapine 50mg tablet, take one to two tablets PO at bedtime PRN. On July 22, 2024, at 12:34 p.m., the surveyor observed ULP-B administer medications to R2. On July 22, 2024, at 9:40 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated ULP's could administer PRN medication without prior authorization, they only needed to contact the nurse if it was a newer medication. On July 23, 2024, at 10:59 a.m., the surveyor inquired how ULPs should decide whether to give one or two tablets for a PRN medication. LALD/CNS-A stated ULPs should not be making decisions on how much medication to give a resident and stated they (LALD/CNS-A) would need to review R2's orders to have the directions changed. On July 23, 2024, at 11:20 a.m., the surveyor	01750		

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01750	Continued From page 14 inquired how ULP-B knew what dose to give to R2 for a PRN medication when there was a choice of giving one or two pills for PRN ibuprofen or quetiapine. ULP-B stated they talked to R2 and asked questions about their level of pain or anxiety and would decide how many pills to give based off R2's answers to their questions. ULP-B stated they did not need to contact the nurse before administering a PRN medication. The licensee's Medication Orders policy dated August 1, 2021, indicated, "[Licensee] will administer medications as prescribed by the authorized prescriber and in accordance with all the rights defined in the Home Care Bill of Rights and in the Health Insurance Portability and Accountability Act." Further it indicated, "[Licensee] will maintain a current written or electronically recorded prescription for all prescribed medications managed for the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01820 SS=F	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for one of	01820		

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01820	Continued From page 15 one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 was admitted to the licensee on July 26, 2023. R2's Service Plan dated July 27, 2023, indicated R2 received services for housekeeping, medication administration, meal reminder, dressing, and bathing assistance. R2's Medication & Treatment Orders form, signed by a provider, indicated R2 was prescribed the following medications: -clonidine 0.1 milligrams (mg) tablet, take by mouth (PO) as needed (PRN); -cyclobenzaprine 10mg tablet, take PO PRN; -fluoxetine 40mg capsule, take PO daily; -hydroxyzine hydrochloride (HCL) 50mg, take PO PRN; -ibuprofen 600mg tablet, take PO PRN; -lisinopril 20mg tablet, take PO daily; -melatonin 3mg tablet, take PO PRN; -naloxone 4mg/0.1 milliliters (ml), take in both nostrils PRN; -olanzapine 5mg tablet, take PO daily; and -quetiapine 200mg tablet, take PO daily. R2's After Visit Summary (AVS) dated March 25, 2024, unsigned by a provider, indicated R2 was prescribed the following medications:	01820		

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01820	Continued From page 16 -acetaminophen 500mg tablet, take two tablets (1000mg) PO every eight hours; -clonidine 0.1mg tablet, take one tablet PO three times a day PRN; -cyclobenzaprine 10mg tablet, take one tablet PO three times a day PRN; -fluoxetine 40mg capsule, take two capsules (80mg) PO daily; -gabapentin 300mg capsule, take two capsules (600mg) PO two times a day; -hydroxyzine HCL 50mg, take one tablet (50mg) PO three times a day PRN; -ibuprofen 600mg tablet, take one to two tablets (600mg-1,200mg) PO PRN; -lisinopril 40mg tablet, take one tablet (40mg) PO daily; -melatonin 3mg tablet, take one tablet PO daily at bedtime; -naloxone 4mg/0.1 milliliters (ml), place one spray (4mg) into one nostril PRN. Call 911. Repeat in opposite nostril in three minutes if no or minimal response; -olanzapine 5mg tablet, take one tablet (5mg) PO daily at bedtime; and -quetiapine 100mg tablet, take two tablets (200mg) PO two times a daily. R2's Med Admin Summary (medication administration record (MAR)) for July 2024, indicated R2 took: -acetaminophen 500mg tablet, take two tablets PO three times daily; -clonidine 0.1mg tablet, take one tablet PO three times a day PRN for anxiety, agitation and restlessness; -cyclobenzaprine 10mg tablet, take one tablet PO three times a day PRN for muscle spasms; -fluoxetine 40mg capsule, take two capsules PO daily; -hydroxyzine hydrochloride (HCL) 50mg, take one	01820		

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01820	Continued From page 17 tablet (50mg) PO three times a day PRN; -ibuprofen 600mg tablet, take one to two tablets PO PRN for moderate pain; -lisinopril 40mg tablet, take one tablet PO daily; -melatonin 3mg tablet, take one tablet PO daily at bedtime PRN for insomnia; -naloxone 4mg/0.1 milliliters (ml) spray, use one spray in a nostril, call 911, if no response in two to three minutes repeat dose in other nostril for suspected opioid overdose; -olanzapine 10mg tablet, take one tablet PO daily at bedtime; and -quetiapine 200mg tablet, take one tablets PO at bedtime; and -quetiapine 50mg tablet, take one to two tablets PO at bedtime PRN. R2's Medication & Treatment Orders form, AVS, and July 2024 MAR lacked or contained contradicting orders. In addition, R2's record lacked a discontinue order for naloxone. On July 22, 2024, at 12:34 p.m., the surveyor observed unlicensed personnel (ULP)-B administer the following medications to R2: -acetaminophen 500mg tablet, take two tablets PO three times daily; -fluoxetine 40mg capsule, take two capsules PO daily; and -lisinopril 40mg tablet, take one tablet PO daily. On July 23, 2024, at 10:41 a.m., the surveyor observed R2's medication drawer with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. The surveyor inquired where R2's naloxone was as it was on R2's MAR and orders. LALD/CNS-A stated R2 no longer needed the naloxone as they were no longer taking opioids for pain management. LALD/CNS-A stated R2 had no substance abuse history and was only	01820		

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01820	Continued From page 18 prescribed due to the pain management opioids. LALD/CNS-A stated they did not have an order to discontinue R2's naloxone. On July 23, 2024, at 10:59 a.m., the surveyor reviewed R2's Medication & Treatment Orders form, AVS and MAR listed above with LALD/CNS-A. The surveyor inquired which document was being used as R2's orders. LALD/CNS-A stated the Medication & Treatment Orders form indicated under, "Treatments," to, "see AVS," so the AVS was what they were using for R2's current orders. The surveyor explained both were signed orders on the same day but the Medication & Treatment Orders form and AVS contradicted each other. The surveyor compared the two documents with LALD/CNS-A and showed the doses for both lisinopril and fluoxetine were contradicting each other with different doses. LALD/CNS-A stated they could see how having both the Medication & Treatment Orders form and AVS as orders was confusing. The surveyor explained there were also discrepancies between R2's Medication & Treatment Orders form, AVS and July 2024 MAR. R2's MAR indicated R2 took quetiapine 50mg at bedtime PRN but was not on R2's Medication & Treatment Orders form or AVS. R2's MAR indicated R2 took a 10mg dose of olanzapine but R2's Medication & Treatment Orders form and AVS indicated they should only have been taking a 5mg dose. R2's AVS indicated R2 was prescribed a 600mg dose of gabapentin but was not on R2's MAR. LALD/CNS-A stated they would get a discontinue order for R2's naloxone right away and get clarification on the discrepancies discussed with the surveyor. LALD/CNS-A stated they were in charge of managing and verifying resident orders.	01820		

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01820	Continued From page 19 On July 23, 2024, at 11:25 a.m., LALD/CNS-A provided an E-Script New Prescription Request form faxed to the licensee by R2's pharmacy on July 23, 2024, at 11:07 a.m. It indicated R2 took olanzapine 10mg tablet PO at bedtime and was electronically signed by R2's provider on May 13, 2024. The licensee's Medication Orders policy dated August 1, 2021, indicated, "Eagle Group Home will maintain a current written or electronically recorded prescription for all prescribed medications managed for the resident." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure expired medications were removed and disposed of for one of one resident (R2). 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	01890		

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01890	Continued From page 20 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 was admitted to the licensee on July 26, 2023. R2's Service Plan dated July 27, 2023, indicated R2 received services for housekeeping, medication administration, meal reminder, dressing, and bathing assistance. R2's After Visit Summary (AVS) dated March 25, 2024, indicated R2 took: -clonidine 0.1 milligram (mg) tablets, take one tablet by mouth (PO) three times a day as needed (PRN). R2's Med Admin Summary (medication administration record (MAR)) for July 2024, indicated R2 was administered clonidine 0.1mg on July 3, 19 and 20, 2024. On July 23, 2024, at 10:41 a.m., the surveyor observed R2's medication drawer in the medication cabinet with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. The surveyor observed a bubble pack of clonidine 0.1mg tablets for R2 which expired on July 15, 2024, eight days prior. LALD/CNS-A stated they didn't realize it was expired. The label indicated: -clonidine 0.1 milligram (mg) tablets, take one to two tablets by mouth (PO) three times a day as needed (PRN). On July 23, 2024, at 11:51 a.m., LALD/CNS-A stated they audit their medication cabinet monthly	01890		

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01890	Continued From page 21 for expired medications. LALD/CNS-A stated R2's medication must have expired after their last check but should have been addressed it before then. The licensee's Disposition and Disposal of Medications dated August 1, 2021, indicated, " Unused portions of current medications being managed by the facility will be given to the resident or responsible party when the resident's service plan ends, medication management services are no longer provided under the service plan or upon discharge; and a note regarding this is placed in the clinical record. Medications for a resident who is deceased or that have been discontinued or expired may be provided for disposal." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

Minnesota Department of Health
Division of Environmental Health, FPLS
PO Box 64975
Saint Paul, 55164-0975
651-201-4500

Type: Full
Date: *07/23/24*
Time: 10:18:53
Report: 1023241147

Food and Beverage Establishment Inspection Report

Location:
Eagle Group Home Llc
6400 Noble Avenue North
Brooklyn Center, MN55429
Hennepin County, 27

Establishment Info:
ID #: 0037961
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6123543024
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.

4-700 Sanitizing Equipment and Utensils

4-702.11 ***** Priority 1 *****

MN Rule 4626.0900 Sanitize utensils and food contact surfaces of equipment before use, after cleaning.

THERE IS NO 3 COMPARTMENT SINK NOR ANSI 184 DISHWASHER AT THIS FACILITY. INSTRUCTED STAFF TO INSTALL REQUIRED EQUIPMENT FOR EFFECTIVE SANITIZATION PROCEDURES. INSTRUCTED STAFF TO USE 3 BUCKET SYSTEM UNTIL EQUIPMENT INSTALLED.

Comply By: 07/23/24

Surface and Equipment Sanitizers

Chlorine: = 100PPM at Degrees Fahrenheit
Location: 3 COMP BUCKET
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/MILK
Temperature: 41 Degrees Fahrenheit - Location: REACH IN COOLER
Violation Issued: No

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

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. INSPECTION CONDUCTED IN PRESENCE OF THE PERSON IN CHARGE.

THIS FACILITY DOES NOT HAVE ALL COMMERCIAL GRADE ANSI EQUIPMENT. ALL FOOD

MUST BE SERVED THE SAME DAY IT IS PREPARED, AND LEFTOVERS CAN NEVER BE SAVED. FOOD SERVICE IS PROVIDED BY FACILITY STAFF.

FOOD SERVICE AREA FLOORS, WALLS, CEILINGS, COUNTERTOPS, AND FINISH MATERIALS MUST BE NON-ABSORBANT, SMOOTH, DURABLE, AND EASILY CLEANABLE. CEILINGS CANNOT HAVE POPCORN TEXTURE. CABINETS CANNOT HAVE HOLLOW BASES. EXPOSED WOOD IS NOT APPROVED FOR FOOD SERVICE AREAS. WOOD IS NOT AN APPROVED FOOD CONTACT SURFACE.

THESE TOPICS WERE DISCUSSED WITH THE PERSON IN CHARGE:
- EMPLOYEE ILLNESS EXCLUSION
- HAND WASHING PROCEDURE
- NO BARE HAND CONTACT WITH RTE FOOD
- VOMIT CLEAN UP PROCEDURE
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS
- ANSI 184 DISH WASHER

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 1023241147 of 07/23/24.

Certified Food Protection Manager: CANDACE WRIGHT

Certification Number: 119623 Expires: 11/04/26

Inspection report reviewed with person in charge and emailed.

Signed: _____

CANDACE WRIGHT
PERSON IN CHARGE

Signed: Gregory T Nelson

Gregory T. Nelson
Public Health Sanitarian
Freeman Building
651-201-4259
greg.nelson@state.mn.us