Electronically delivered

May 10, 2022

Administrator
Eagle Group Home, LLC
2653 14th Avenue South
Minneapolis, MN 55407

RE: Project Number(s) SL35131015

Dear Administrator:

On April 28, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on February 10, 2022. The follow-up evaluation determined your facility had not corrected all of the state licensing orders issued pursuant to the February 10, 2022 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on February 10, 2022, found not corrected at the time of the April 28, 2022, follow-up evaluation and/or subject to penalty assessment are as follows:

0490-Minimum Requirements-144g.41 Subd 1 (13) (ii)-(vii) = $500.00
0970-Waivers Of Liability Prohibited-144.50 Subd. 5 = $500.00

The details of the violations noted at the time of this follow-up evaluation completed on April 28, 2022 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,000.00**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order by the correction order date. The commissioner may request a copy of this documentation and the assisted living facility's action to respond to the correction orders in future evaluations, upon a complaint investigation, and as otherwise needed.

IMPOSITION OF FINES:
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.

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you have one opportunity to challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. This written request must be received by the Department of Health within 15 calendar days of the correction order receipt date. Please send your written request via email to the following:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970
Health.HRD.Appeals@state.mn.us

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

We urge you to review these orders carefully. If you have questions, please contact Jess Gallmeier at 651-247-0268.

Please note, 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.

Sincerely,

Jess Gallmeier, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-247-0268 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35131	A. BUILDING: _____ B. WING _____	R 04/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE GROUP HOME LLC	2653 14TH AVENUE SOUTH MINNEAPOLIS, MN 55407

(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 Initial comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: Project # SL35131015-1 On April 28, 2022, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on February 10, 2022. At the time of the survey, there were four residents receiving services under the Assisted Living license. As a result of the revisit, the following orders were reissued.	{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 Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
{0 490} SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements	{0 490}		

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{0 490}	Continued From page 1 (ii) weekly housekeeping; (iii) weekly laundry service; (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to have a daily program of social and recreational activities based on individual and group interests, physical, mental, and psychosocial needs, that create opportunities for active participation in the community at large. This had the potential to affect all four residents of the facility. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	{0 490}		

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{0 490}	Continued From page 2 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 April 28, 2022, at approximately 1:45 p.m., the surveyor did not observe any activities were planned for the residents. On April 28, 2022, throughout the survey, the surveyor observed residents remained in their rooms a majority of the time, and when a resident exited a room, they paced back and forth to the kitchen and common area. On April 28, 2022, at 2:00 p.m., the surveyor requested documents the licensee had for daily programming of social and recreational activities. Unlicensed personnel (ULP)-B stated the licensee did not have any. On April 28, 2022, at approximately 3:10 p.m., ULP-B acknowledged the licensee lacked a daily program of social and recreational activities. ULP-B stated the residents are busy going in and out of the assisted living. In addition, ULP-B stated when a resident wants to engage in an activity, the staff would assist. No further information was provided.	{0 490}		
{0 790} SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire	{0 790}		

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{0 790}	Continued From page 3 Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: No further action required.	{0 790}		
{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: No further action required.	{0 800}		
{0 970} SS=F	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a	{0 970}		

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{0 970}	Continued From page 4 lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1's record included a copy of the Assisted Living Contract, dated August 1, 2021. R1's Assisted Living Contract included a section titled Indemnification. The section indicated R1 waived liability (responsibility) of the licensee for the health and safety or personal property of a resident. On April 28, 2022, at approximately 2:20 p.m., registered nurse (RN)-A acknowledged the licensee's assisted living contract included a waiver of the licensee's liability for health and safety or personal property. RN-A also acknowledged the same contract is used for all the licensee's residents. No further information provided.	{0 970}		

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{01890} SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information for one of two residents (R3) and failed to discard expired medication for one of two residents (R4) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On April 28, 2022, at approximately 2:15 p.m., the surveyor observed a locked medication file cabinet that contained acetaminophen extra strength 500 milligram (mg) bottle with expiration date of April 19, 2022, for R4. On April 28, 2022, at approximately 2:18 p.m., the	{01890}		

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{01890}	Continued From page 6 surveyor observed fluticasone propionate nasal spray 50 micrograms (mcg) metered spray without a prescription label in R3's medication file cabinet drawer. The nasal spray did not indicate a resident, the dosage, or how to administer the medication. On April 28, 2022, at approximately 2:20 p.m., registered nurse (RN)-A and unlicensed personnel (ULP)-B acknowledged the nasal spray did not have a prescription label and the acetaminophen extra strength 500 mg was expired. RN-A stated R3 no longer used the medication. In addition, RN-A stated medications were going to be destroyed. The surveyor observed RN-A take medication to the nursing office to be destroyed. The licensee's Storage/Control of Medications policy, dated August 1, 2021, indicated prescription drugs must be kept in original container and bear the original prescription label with legible information. In addition, the nurse would check expiration dates and would note medication needing to be reordered. No further information was provided.	{01890}		

Electronically Delivered

March 22, 2022

Administrator
Eagle Group Home LLC
2653 14th Avenue South
Minneapolis, MN 55407

RE: Project Number(s) SL35131015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on February 10, 2022, 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 Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES
In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and 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), 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, the following fines are assessed pursuant to this evaluation:

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00

The total amount you are assessed is $500.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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 by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. 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 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 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.

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 addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

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,

Jess 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
Phone: 651-247-0268 Fax: 651-215-9697

HHH

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0 000	Initial Comments 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: SL#35131015 On February 9, 2022, through February 10, 2022, 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 3 residents receiving services under the provider's 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 Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's three residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: On February 9, 2022, at approximately 10:15 a.m., during the entrance conference, registered nurse (RN)-A identified self as the LALD for licensee. RN-A obtained an assisted living director license on January 11, 2022. On February 9, 2022, at approximately 10:58 a.m., the Board of Executives for Long-Term Services and Support (BELTSS) website indicated RN-A held a current assisted living director license but not listed as Director of Record for the licensee.	0 110		

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0 110	Continued From page 2 On February 9, 2022, at approximately 12:15 p.m., RN-A acknowledged they were not listed as the Director of Record for licensee and would contact BELTSS for correction. The licensee's Position Description Director, dated 2021, indicated the LALD would be licensed with BELTSS however, lacked the requirement of the LALD to be registered as the Director of Record for facility. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days Corrected on February 10, 2022	0 110		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or	0 470		

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	35131	A. BUILDING: _____ B. WING _____	02/10/2022

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0 470	Continued From page 3 safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the required staffing plan was posted in a central location, potentially affecting the licensee's three current residents, staff, and any visitors of the licensee. 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 February 9, 2022, at approximately 10:40 a.m., the surveyor observed the posted staff schedule which only identified the staff, the day of the week and the shifts as "shift 1, shift 2 and shift 3," but lacked the hours worked. On February 9, 2022, at approximately 10:45 a.m., administrator/unlicensed personnel (ULP)-B, acknowledged the posted staffing	0 470		

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0 470	Continued From page 4 schedule lacked the hours worked. The licensee's Staffing policy, dated August 1, 2021, indicated the registered nurse will prepare and implement a 24-hour staffing schedule that meets resident needs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		
0 485 SS=C	144G.41 Subd 1. (13) (i) (A) and (C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance, and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; (C) the facility cannot require a resident to include and pay for meals in their contract; This MN Requirement is not met as evidenced by:	0 485		

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0 485	Continued From page 5 Based on observation and interview, the licensee failed to have a menu prepared at least one week in advance and made available to all residents. This had the potential to affect all three residents of the facility. 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: On February 10, 2022, at approximately 10:30 a.m., the surveyor observed the menu plan on bulletin board. The observed menu was not prepared at least one week in advance and lacked dates of the week. On February 10, 2022, at approximately 10:55 a.m., administrator/unlicensed personnel (ULP)-B stated the menu is made available to residents by use of the bulletin board. ULP-B acknowledged the menu plan on the bulletin board was what residents had available. The licensee's policy for meal and menu requirements was requested but not provided. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		

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0 490	Continued From page 6	0 490		
0 490 SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (ii) weekly housekeeping; (iii) weekly laundry service; (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a daily program of social and recreational activities based on individual and group interests, physical, mental, and psychosocial needs, that create opportunities for active participation in the community at large. This had the potential to affect all three residents of the facility. This practice resulted in a level two violation (a	0 490		

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0 490	Continued From page 7 violation that did not harm a client'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 February 9, 2022, at approximately 10:20 a.m., during the entrance conference, a request was made to see the licensee's daily program of social and recreational activities. On February 9, 2022, at approximately 12:15 p.m., the surveyor did not observe any activities were planned or offered to the residents. Residents remained in their rooms most of the day, and some paced back and forth to the kitchen, outside, and to their rooms. On February 10, 2022, at approximately 12:05 p.m., unlicensed personnel (ULP)-B acknowledged the licensee did not have a daily program of social and recreational activities, and stated residents are kept busy with some activities, though they did not have a daily activity program developed. The licensee's policy for daily program of social activities requested but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 490		

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0 510	Continued From page 8	0 510		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control related to COVID-19. This had the potential to affect all three residents, staff, and visitors at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 failed to ensure staff and visitors entering or re-entering the building were	0 510		

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0 510	Continued From page 9 screened for COVID-19 with documented temperatures and symptom screening questions. The licensee also failed to ensure staff wore eye protection while in the residents' care areas. The Minnesota Department of Health's (MDH) electronic COVID-19 Toolkit: Information for Long Term Care Facilities, dated March 8, 2021, indicated on page 7: Screen all staff for fever and symptoms of illness before starting each shift. In addition to staff, conduct health screening for other essential health care personnel including therapy personnel, hospice, home care, dialysis, ombudsman, state surveyors, chaplain at end of life, mortician, etc. Conduct assessment for fever and ask about new symptoms of illness (measured or subjective fever, cough, shortness of breath, chills, headache, muscle pain, sore throat, or new loss of taste or smell). The Minnesota Department of Health (MDH) document titled, COVID-19 Toolkit, Information for Long Term Care Facilities, dated March 8, 2021, indicated on page 8, all staff should wear a well-fitting mask and eye protection (e.g. face shield, goggles) when in resident care areas. On February 9, 2022, at approximately 9:35 a.m., the surveyors arrived at the licensee's facility but neither screening for COVID-19 symptoms was completed, nor temperature checked. On February 9, 2022, at approximately 10:15 a.m., registered nurse (RN)-A arrived and checked her temperature and recorded but no COVID-19 symptom screening was completed. On February 9, 2022, at approximately 11:30 a.m., and 12:20 p.m., the environmental and the engineering surveyors arrived, and temperature	0 510		

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0 510	Continued From page 10 was checked and recorded but no COVID-19 symptom screening was completed. On February 9, 2022, at approximately 12:40 p.m., RN-A and unlicensed personnel (ULP)-B were with the residents in the kitchen area but did not have eye protection on, neither did the residents have their masks on. On February 10, 2022, at approximately 11:40 a.m., two vendors arrived at the licensee to do maintenance work. The vendors' temperatures were checked, but no COVID-19 symptom screening was completed. On February 10, 2022, at approximately 12:30 p.m., RN-A acknowledged the licensee did not screen for COVID-19 symptoms and stated ULP-B was scared of the surveyors and forgot to complete screening and check temperature. The licensee's Infection Control policy, dated August 1, 2021, indicated the licensee will observe the recommended precautions as identified by the Centers for Disease Control and Prevention (CDC). "The practice of employees will conform with OSHA regulations, current law and currently accepted health care, medical and nursing standards of practice for infection control". No further information was provided. TIME PERIOD FOR CORRECTION: Seven days (7) days	0 510		
0 630 SS=D	144G.42 Subd. 6 Compliance with requirements for reporting ma	0 630		

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0 630	Continued From page 11 (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of one resident (R1) with record reviewed. 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: R1 was admitted to the license August 1, 2021. R1's diagnoses included schizophrenia (a mental illness characterized by delusions, hallucinations, disorganized thoughts, speech and behavior) and anxiety. R1's IAPP, dated November 29, 2021, indicated	0 630		

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0 630	Continued From page 12 R1 had a history of suicide, history of alcohol use not prescribed, impaired judgment, and isolation. R1's IAPP did not have the specific interventions for each assessed vulnerability to be taken to minimize the risk of abuse to that person and other vulnerable adults. On February 10, 2022, at approximately 10:50 a.m., registered nurse (RN)-A, acknowledged R1's IAPP was lacking specific interventions for assessed vulnerability and stated the licensee's documentation software did not update the resident's IAPP when the latest assessment was completed. The licensee's Vulnerable Adult policy, dated August 1, 2021, indicated the licensee will assess residents to determine vulnerability to abuse or neglect and develop a specific plan to minimize the risk of abuse to that resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
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;	0 680		

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0 680	Continued From page 13 (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 tenant 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 review, the licensee failed to have a written emergency disaster preparedness plan with all the required content. This had the potential to affect all three residents receiving services under licensee. 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: On February 9, 2022, at approximately 10:25 a.m., during the entrance conference, the surveyor requested to review the licensee's	0 680		

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0 680	Continued From page 14 emergency disaster preparedness plan. On February 9, 2022, at approximately 10:35 a.m., during the facility tour, the surveyor observed at the main entrance a posted emergency evacuation plan and emergency exit signage on the main and kitchen doors. The assisted living facility had three shared common areas for residents, staff, and visitors to include a living room, dining room and kitchen, all on the same level. The licensee's emergency disaster preparedness plan lacked required content to include: -current, all-hazards approach facility assessment; -description of the population served by licensee; -process for emergency preparedness (EP) cooperation with state and local EP officials/organizations; -subsistence needs for staff and residents during emergency situation; -procedure for tracking staff and residents; -development of all policies/procedures, based on assessment; and additional policies for: -potential evacuation; -sheltering in place; -handling medical documents; -handling and use of volunteers; -arrangement with other faculties (including sister facilities); -development of a communication plan, including primary and alternate means for communication; -methods for sharing information/family notifications; -EP training and testing program; -EP training program for staff (including documentation of training provided); and -EP testing/annual testing requirements.	0 680		

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0 680	Continued From page 15 On February 10, 2022, at approximately 11:40 a.m., registered nurse (RN)-A acknowledged the licensee lacked a written emergency disaster preparedness plan to include the above content, and stated the licensee will update the emergency preparedness plan. The licensee's Emergency Preparedness policy, dated August 1, 2021, indicated the licensee will have a plan in place to assure the safety and well-being of residents and staff during periods of emergency or disaster that disrupts services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure installation and maintenance of portable fire extinguishers at the facility. This had	0 790		

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0 790	Continued From page 16 the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 residents). The findings include: On February 09, 2022, from approximately 11:15 a.m. to 11:45 a.m., survey staff toured the facility with the administrator/unlicensed personnel (ULP)-B. During the facility tour, survey staff observed the wrong size portable fire extinguisher installed. ULP-B verbally confirmed survey staff observations during the facility tour. ULP-B stated they would get the larger size installed immediately. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 790		
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	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35131	A. BUILDING: _____ B. WING _____	02/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE GROUP HOME LLC	2653 14TH AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 800	Continued From page 17 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 facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 residents). The findings include: On February 09, 2022, from approximately 11:15 a.m. to 11:45 a.m., survey staff toured the facility with the administrator/unlicensed personnel (ULP)-B. During the facility tour, survey staff observed the following: 1. Basement had cobwebs and staining on many surfaces including doors, door frames, walls, and light switches. 2. Basement carpet on steps and floor had clear wear pattern and staining. 3. First-floor restroom had a broken towel holder protruding from the wall. 4. Upstairs bedroom #1 had a bifold closet door	0 800		

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	35131	A. BUILDING: _____ B. WING _____	02/10/2022

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0 800	Continued From page 18 that was off the track. When ULP-B attempted to pop it back onto the track, the whole door fell off the track. 5. Upstairs bedroom #2 had staining on the walls, doors, and light switches. Dried, bloody nasal discharge was smeared on large portions of the wall next to the closet and bed. 6. Upstairs bedroom #3 had heavily soiled duct grilles. ULP-B verbally confirmed survey staff observations during the facility tour. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 970 SS=F	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to	0 970		

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0 970	Continued From page 19 affect all three residents. 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: On February 9, 2022, at approximately 11:20 a.m., registered nurse (RN)-A provided a blank Assisted Living Contract and indicated the contract is used by the licensee for all residents who received services. R1's record included a copy of the Assisted Living Contract, dated August 1, 2021. The Assisted Living Contract included sections titled Miscellaneous Provisions, Insurance Liability and Release, and Primary Services. The sections indicated the resident waived liability (responsibility) of the licensee for the health and safety or personal property of a resident. On February 10, 2022, at approximately 2:00 p.m., RN-A acknowledged the licensee's assisted living contract included a waiver of the licensee's liability for health and safety or personal property. The licensee's Assisted Living Contract policy requested but was not provided. No further information provided. TIME PERIOD FOR CORRECTION:	0 970		

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0 970	Continued From page 20 Twenty-One (21) days	0 970		
01620 SS=D	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 licensee failed to ensure the registered nurse (RN) completed a reassessment not to exceed 90 days for one of one resident (R1) as required with record reviewed. This practice resulted in a level two violation (a	01620		

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01620	Continued From page 21	01620		

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:

R1 started services with the licensee on June 1, 2020.

R1's diagnoses include schizophrenia (a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions) and anxiety.

R1's service plan, dated August 1, 2021, indicated R1 received services which included activity assistance, bathing assistance, housekeeping, behavior management, medication administration, meal reminders, staff supervision, monitoring, and assessments.

R1's record included a 90-day assessment completed on July 7, 2021, and a 90-day assessment completed on November 29, 2021. R1's 90-day reassessment exceed 90 calendar days from the date of the last review.

On February 9, 2022, at approximately 2:05 p.m., RN-A acknowledged R1's 90-day assessment exceeded 90 days from previous assessment.

The licensee's Assessment and Reassessment policy, effective August 1, 2021, indicated reassessment cannot exceed 90 days from

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01620	Continued From page 22 previous assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current 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		

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01650	Continued From page 23 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 one of one resident (R1) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 admitted to licensee on August 1, 2021. R1's service plan, dated August 1, 2021, indicated R1 received services to include activity assistance, bathing assistance, housekeeping, behavior management, medication administration, meal reminders, staff supervision, monitoring, and assessments. R1's service plan lacked: - the fees for services - information and a method to contact the licensee - 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 - the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made	01650		

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01650	Continued From page 24 by the resident under those chapters On February 9, 2022, at approximately 12:20 p.m., registered nurse (RN)-A acknowledged R1's service plan lacked the content above also stated they will update all resident service plans to reflect the required content. The licensee's Service Plan policy, dated August 1, 2021, indicated all the missing content is included in a service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01690 SS=D	144G.71 Subdivision 1 Medication management services (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and	01690		

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01690	Continued From page 25 evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to implement and maintain current medication management policy and procedures developed under the supervision and direction of a registered nurse (RN) consistent with current practice standards and guidelines, for one of one resident (R3) with record reviewed. 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 February 10, 2022, at approximately 9:50 a.m., unlicensed personnel (ULP)-B administered dextroamphetamine-amphetamine 15 milligrams	01690		

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01690	Continued From page 26 (mg) to R3. ULP-B lacked documentation on the controlled substance after administration. R3's service plan, dated August 1, 2021, indicated R3 received medication administration. R3's signed medication and treatment orders, dated December 21, 2021, indicated R3's medications included dextroamphetamine-amphetamine 15 mg, Zoloft 50 mg, Xanax 2mg, and hydroxyzine 50mg. On February 10, 2022, at approximately 10:05 a.m., registered nurse (RN)-A stated her protocol for controlled substances is located in RTasks system (electronic medical documentation system). RN-A stated RTasks ensures ULPs put in the amount of remaining controlled substance after administration. RN-A stated if the amount remaining does not match, RTasks will send out an alert. RN-A acknowledged that R3's dextroamphetamine-amphetamine 15 mg was not accounted for. RN-A added R3's dextroamphetamine-amphetamine 15 mg to the RTasks controlled substance count. The licensee's Storage/Control of Medications policy, dated August 1, 2021, indicated the RN is responsible for establishing a protocol related to monitoring and securing controlled medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01690		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for	01890		

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01890	Continued From page 27 immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information for one of one resident (R3) with record reviewed. 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 February 10, 2022, at approximately 9:50 a.m., the surveyor observed fluticasone propionate nasal spray 50 micrograms (mcg) metered spray without a prescription label in R3's medication box. The nasal spray did not indicate a resident, the dosage or how to administer medication. On February 10, 2022, at approximately 9:52 a.m., registered nurse (RN)-A and unlicensed personnel (ULP)-B acknowledged the nasal spray did not have a prescription label. RN-A also stated it was a discontinued medication for the	01890		

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01890	Continued From page 28 resident. The licensee's Storage/Control of Medications policy, dated August 1, 2021, indicated prescription drugs must be kept in original container and bear the original prescription label with legible information. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

Minnesota Department of Health

625 North Robert Street
Saint Paul, MN
651-201-5000

Type: Full
Date: *02/09/22*
Time: 10:00:00
Report: 8087221044

Food and Beverage Establishment Inspection Report

Location:
Eagle Group Home Llc
2653 14th Avenue South
Minneapolis, MN55407
Hennepin County, 27

Establishment Info:
ID #: 0037844
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.

No NEW orders were issued during this inspection.

Food and Equipment Temperatures

Process/Item: Ambient Air
Temperature: 4 Degrees Fahrenheit - Location: FREEZER
Violation Issued: No

Process/Item: Ambient Air
Temperature: 37 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding: MILK
Temperature: 36 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding: MILK
Temperature: 37 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding: CHEESE
Temperature: 36 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

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

THIS WAS AN ANNOUNCED AND SCHEDULED FULL INSPECTION.

INSPECTION CONDUCTED IN THE PRESENCE OF NURSE EVALUATOR II BENARD NYANGENA (HRD SURVEY STAFF SUPERVISOR).

FLOOR IS TILED AND CABINETS ARE HARDWOOD. CEILING APPEARS TO BE UNAPPROVED

PAINTED SHEET ROCK. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

MAYTAG BRAND DISHWASHER IS RESIDENTIAL BUT HAS SANITIZING RINSE CYCLE OPTION.

REFRIGERATOR IS RESIDENTIAL GE BRAND.

HOT WATER TEMPERATURE AT THE KITCHEN SINK REACHED 120 DEGREES.

NO DESIGNATED HAND WASHING SINK IN THE KITCHEN, ONLY A 2-BIN, STAINLESS STEEL RESIDENTIAL KITCHEN SINK.

KITCHEN COUNTERS ARE MADE OF A FORMICA-LIKE MATERIAL AND APPEAR TO BE IN GOOD CONDITION.

MICROWAVE IS SAMSUNG BRAND.

THERE IS NO FULL TIME STATE CERTIFIED FOOD PROTECTION MANAGER AT THE ESTABLISHMENT. HIRE A FULL TIME EMPLOYEE OR TRAIN AN EXISTING FULL TIME EMPLOYEE AND APPLY FOR THE STATE CERTIFIED FOOD PROTECTION MANAGER CERTIFICATE.

INSPECTION REPORT EMAILED TO BENARD NYANGENA (HRD SURVEY STAFF SUPERVISOR).

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 8087221044 of 02/09/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
CANDACE WEIGHT
RESIDENT NURSE

Signed:_____
John Boettcher
Public Health Sanitarian 3
St. Paul, MN / Freeman
651-201-5076
john.boettcher@state.mn.us