



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

September 23, 2026

Licensee

Eagle Group Home LLC

3414 Oakland Avenue South

Minneapolis, MN 55407

RE: Project Number(s) SL35094016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 2, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;

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

Level 3: a fine of \$1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 4: a fine of \$3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

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

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

St - 0 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - \$500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

REQUESTING A HEARING

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

factor.

To submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEpHV>**. Your input is important to us and will enable MDH to improve its processes and communication with providers.

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in cursive script that reads "Renee L. Anderson".

Renee L. Anderson, Supervisor

State Evaluation Team

Email: Renee.L.Anderson@state.mn.us

Telephone: 651-201-5871 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35094	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/02/2026
NAME OF PROVIDER OR SUPPLIER EAGLE GROUP HOME LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3414 OAKLAND 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 *****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: SL35094016-0 On August 31, 2026, through September 2, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were four residents; four receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control	0 660			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 660	Continued From page 1 (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), to include baseline testing (either by a two-step tuberculin skin test (TST) or a single interferon gamma release assay (IGRA) TB blood test) for one of three employees (unlicensed personnel (ULP)-C). 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).	0 660			

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0 660	Continued From page 2 The findings include: The licensee's TB Facility Risk Assessment worksheet, dated May 1, 2026, indicated the facility was at low risk for TB transmission. ULP-C was hired November 8, 2024, to provide direct care for the licensee's residents. On September 1, 2026, at 7:55 a.m., the surveyor observed ULP-C assist R2 with medication administration. ULP-C's employee record included an initial one step TST dated November 11, 2024, but lacked a two-step tuberculin skin test (TST) or a single interferon gamma release assay (IGRA-TB blood test) within 90 days of hire date. On September 1, 2026, at 8:50 a.m., administrator (A)-B stated she could not find a second step TST in ULP-C's employee record. On September 1, 2026, at 9:00 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS) stated ULP-C's second step TST must have been missed, and this was the reason the licensee preferred to have employees have a TB blood test completed instead of the two step TST. The licensee's Tuberculosis Screening/Prevention policy dated December 1, 2025, indicated, "TB Screening: The CDC guidelines (2019) for preventing Mycobacterium tuberculosis transmission in health care settings include the following recommendations: "1) TB screening with an individual risk assessment and symptom evaluation at baseline (preplacement); 2) TB testing with an interferon-gamma release	0 660			

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0 660	Continued From page 3 assay (IGRA) or a tuberculin skin test (TST) for persons without documented prior TB disease or latent TB infection (LTBI); 3) no routine serial TB testing at any interval after baseline in the absence of a known [Consultant] 2022 Policy 4.14 Tuberculosis Screening/Prevention exposure or ongoing transmission; 4) encouragement of treatment for all health care personnel with untreated LTBI, unless treatment is contraindicated; 5) annual symptom screening for health care personnel with untreated LTBI; and 6) annual TB education of all health care personnel. "Baseline testing is completed on hire for all direct care providers and anyone who visits residents (including volunteers). Test results 1) provide a basis for comparison in the event of a potential or known exposure to M. tuberculosis and 2) facilitate the detection and treatment of LTBI or TB disease in a staff member before employment begins and reduces the risk to patients and other staff members." The CDC's Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel: Recommendations from the National Tuberculosis Controllers Association and CDC dated May 16, 2019, recommended all health care professionals complete a TB screening including a symptom evaluation and an IGRA or TST. Health care workers with written documentation of a previous positive TST or IGRA should have documented in their record: test results, assessment for current TB symptoms and a related chest x-ray. The Minnesota Department of Health (MDH) Regulations for TB Control in Minnesota Health Care Settings, dated July 2013, indicated baseline TB screening consists of three components:	0 660			

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0 660	Continued From page 4 1. Assessing for current symptoms of active TB disease, 2. Assessing TB history, and 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single IGRA. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
0 680 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	0 680			

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0 680	Continued From page 5 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 preparedness plan (EPP) with all the required content. This had the potential to affect all residents receiving services under the provisional assisted living license. 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's EPP dated May 17, 2026, lacked the following required content: -policies and procedures for subsistence needs for staff and residents; -policies and procedures for tracking of staff and residents; and -emergency prep testing requirements. On September 2, 2026, at 9:04 a.m., administrator (A)-B stated she was working on the facility EPP and getting the documents updated in the binder that was kept at the facility for employees. Also, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee was still working on updating their EPP to be compliant with state requirements. LALD/CNS-A verified the following	0 680			

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0 680	Continued From page 6 missed components: -policies and procedures for subsistence needs for staff and residents; -policies and procedures for tracking of staff and residents; and -emergency prep testing requirements. The licensee's Emergency Preparedness policy dated December 1, 2025, 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. 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." Minnesota Administrative Rule 4659.0100 dated August 11, 2021, indicated assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations title 42, section 483.72, or successor requirements. This part referenced documents, specifications, methods, and standards in State Operations Manual Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types: Interpretive Guidance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 730 SS=F	144G.43 Subd. 3 Contents of resident record	0 730			

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0 730	Continued From page 7 Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and	0 730			

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0 730	Continued From page 8 any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the resident record included accurate documentation that services had been provided as identified in the service plan for four of four residents (R2, R3, R4, R5). 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: R2 R2 was admitted on August 27, 2025, and had diagnoses including bipolar disorder (a mental health disorder), depression, and post-traumatic stress disorder (PTSD). On September 1, 2026, at 7:55 a.m., the surveyor observed unlicensed personnel (ULP)-C assist R2 with medication administration. R2's Service Plan (Waiver) - Addendum to	0 730			

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0 730	Continued From page 9 Contract, dated August 12, 2026, indicated R2 received services including assistance with behavior management three times per day, daily for agitation, depression, hoarding, self-isolation, verbal aggression, and paranoia. R2's Service Recap Summary dated August 1, 2026, through August 31, 2026, lacked documentation the above behavior management services were provided, or the reason a service was not provided as scheduled for 11:00 p.m., for the following dates: -August 3 through August 7, (5 days); -August 11 through August 16, (8 days); -August 18, (one day); -August 20 through August 23, (4 days); and -August 25, through August 31, (7 days). R3 R3 was admitted on May 21, 2024, and had diagnoses including bipolar disorder (a mental health disorder), attention deficit hyperactivity disorder (ADHD), anemia, multiple sclerosis (chronic disease that affects the central nervous system, which includes the brain, spinal cord, and optic nerves), and asthma. R3's Service Plan (Waiver) - Addendum to Contract, dated August 12, 2026, indicated R3 received services including assistance with vital signs daily, weight monitoring once per week, and behavior management three times per day, daily for anxiety, depression, paranoia, and wandering. R3's Service Recap Summary - Month dated August 2026, lacked the following services were provided, or the reason a service was not provided: -vital signs (blood pressure, oxygen saturation, pulse, respiration, temperature) daily, August 1-2,	0 730			

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0 730	Continued From page 10 7, 15-16, 22, 24-26, and 29-30; -weight (one day a week), on August 25; and -managing behaviors (anxiety, depression, paranoia, and wandering-three times per day), August 1-2, 7 in the morning (AM) and evening (PM). Also, August 1, 3-7, 11-16, 18, 20-24, 26-31, at 11:00 p.m. R4 R4 was admitted on November 30, 2024, and had diagnoses including schizoaffective disorder, bipolar type (a mental health disorder). R4's Service Plan (Waiver) - Addendum to Contract, dated August 12, 2026, indicated R4 received services including assistance with vital signs daily, grooming daily, and behavior management three times per day, daily for agitation, self-isolation, verbal aggression, delusions, and paranoia. R4's Service Recap Summary - Month dated August 2026, lacked documentation the following services were provided, or the reason a service was not provided: -vital signs (blood pressure, oxygen saturation, pulse, respiration, temperature) daily, August 1-2, 7, 15-16, 22, 24-26, 29-30; -grooming (Midday), August 1-31; and -managing behaviors (agitation, self-isolation, verbal aggression, delusions, and paranoia-three times per day), August 2, in the morning (AM); August 1-2, 29 in the evening (PM); and August 1, 3-7, 11-16, 18, 20-31. R5 R5 was admitted on December 1, 2023, and had diagnoses including bipolar disorder (a mental health disease), ADHD, depression, anxiety, and history of substance abuse.	0 730			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 730	Continued From page 11 R5's Service Plan (Waiver) - Addendum to Contract, dated August 12, 2026, indicated R5 received services including assistance with behavior management two times per day, daily for anxiety, and physical aggression. Three times per day, daily for verbal aggression. Additionally, R5 would have safety checks three times per day. R5's Service Recap Summary dated August 1, 2026, through August 31, 2026, indicated R5 was absent from the facility August 11 through August 13; August 21 through August 24; and August 28, through August 31. Of the days R5 was present at the facility, R5's Service Recap Summary lacked documentation, the above behavior management and safety check services were provided, or the reason the services were not provided at 11:00 p.m., for the following dates: -August 1 through August 10, (10 days); -August 14 through August 20, (7 days); and -August 25 through August 27, (3 days). On September 2, 2026, at 1:12 p.m., administrator (A)-B stated, via phone, she was aware there was missed documentation of services completed for the licensee's residents. A-B verbalized this was another education topic needing to be reviewed with employees. A-B stated the employees should be documenting in all sections on the service recap summary or documenting the reason a service was not provided or declined by the resident. A-B verbalized with behavior documentation the employees should be documenting on every shift and noting the frequency of a behavior exhibited by the resident. The licensee's Clinical records policy dated December 1, 2025, indicated, "3. Documentation	0 730			

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0 730	Continued From page 12 will be entered into the clinical record no later than two weeks after the end of the day service was provided." Also, included under number 6, "The clinical record contains the following information: Documentation of services provided as identified in the service plan." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730			
0 775 SS=D	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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:	0 775			

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0 775	Continued From page 13 Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated September 3, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;	0 780			

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0 780	Continued From page 14 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated September 3, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780			
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			

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0 800	Continued From page 15 residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated September 3, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800			
01530 SS=D	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the	01530			

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01530	Continued From page 16 following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter;	01530			

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01530	Continued From page 17 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the required one hour of training on topics related to mental illness and de-escalation was completed for each 12 months of employment for one of three employees (unlicensed personnel (ULP)-C). 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: ULP-C was hired November 8, 2024, to provide direct care for the licensee's residents. On September 1, 2026, the surveyor observed ULP-C assist R2 with medication administration. ULP-C's employee record included two hours of initial mental illness and de-escalation training dated November 8, 2024, and November 11, 2024, but lacked documentation she completed the required one hours of annual training on mental illness and de-escalation topics completed for each 12 months of employment thereafter. On September 1, 2026, at 9:00 a.m., administrator (A)-B stated she could not find ULP-C's one hour of annual training for the last 12 months of employment, so this must have	01530			

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01530	Continued From page 18 been missed. The licensee's Education on Mental Illness and De-escalation policy dated December 1, 2025, indicated, "6. Direct care employees will complete at least one (1) hour of education on topics related to mental illness with de-escalation for each twelve (12) months of employment thereafter." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation	01620			

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01620	Continued From page 19 of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a comprehensive reassessment at least every 90 days for one of two residents (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	01620			

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01620	Continued From page 20 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: R2 was admitted to the licensee on August 27, 2025, with a diagnosis of bipolar disorder (a mental health disorder), depression, and post-traumatic stress disorder (PTSD). R2's Service Plan dated August 12, 2026, indicated the services provided included activity assistance, behavior management, medication administration, and transfer assistance. R2's electronic medical record (EMR) included a Clinical Update assessment (return from hospital) dated January 7, 2026. R2's next Clinical Update assessment (90 day) was dated May 22, 2026, which was 100 days after the previous assessment. On September 1, 2026, at 7:55 a.m., the surveyor observed unlicensed personnel (ULP)-C administer R2's morning medications. On September 1, 2026, at 10:38 a.m., the licensed assisted living director/clinical nurse specialist (LALD/CNS)-A stated she was not sure why the comprehensive assessment was late, R2 resided in the facility during the times of the assessment due dates, and the LALD/CNS-A stated she knew the 90 day timeline requirement for comprehensive assessments. The licensee's Assessment and Reassessment policy, dated December 1, 2025, indicated, "8.	01620			

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01620	Continued From page 21 Ongoing resident reassessments must be conducted by an RN and cannot exceed 90 days from the last date of assessment." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a current	01640			

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01640	Continued From page 22 written service plan was revised to reflect the current services provided for two of four residents (R2 and R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2 R2 was admitted on August 27, 2025, and had diagnoses including bipolar disorder (a mental health disorder), depression, and post-traumatic stress disorder (PTSD). R2's Service Plan dated August 12, 2026, indicated the services provided included activity assistance daily, behavior management three times per day, daily, for agitation, depression, hoarding, self-isolation, verbal aggression; and paranoia; and transfer assistance daily. R2's Department of Human Services (DHS) Support Plan dated June 1, 2026, through May 31, 2027, identified Individual Staff Ratio 1:1 was authorized for 2.75 units per day (41.25 minutes). No units were authorized for transfers. R2's Service Recap Summary dated August 1, 2026, through August 31, 2026, lacked documentation individual staff ratio 1:1 service was provided, however assistance with transfers	01640			

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01640	Continued From page 23 was signed off as being completed 30 out of 31 days, with one of those days signed off as "declined". During intermittent observations during survey August 31, 2026, through September 2, 2026, R2 walked up and down the stairs independently, cleaned items off the floor in her room and put them in a trash bag, sat down and got up from a seated position independently and socialized with individual staff members to reduce her anxiety. R5 R5 was admitted to the licensee on December 1, 2023, with diagnoses including bipolar disorder (a mental health disorder), attention deficit hyperactivity disorder (ADHD), depression, anxiety, and history of substance abuse. R5's Service Plan (Waiver) - Addendum to Contract, dated August 12, 2026, indicated R5 received services including housekeeping, meals, laundry, activity assistance, activities of daily living (ADLs), vital signs, safety checks, socialization, behavior management, and medication administration. R5's Department of Human Services (DHS) Support Plan dated October 1, 2025, to September 30, 2026, identified Individual Staff Ratio 1:1 was authorized for 2.5 units per day (37.5 minutes), and 3 units per week (45 minutes) for shopping. R5's Service Recap Summary dated August 1, 2026, through August 31, 2026, lacked documentation individual staff ratio 1:1 service and shopping were being provided. On September 2, 2026, from 9:20 a.m. to 9:50	01640			

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01640	Continued From page 24 a.m., during a conversation with both licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A and administrator (A-B) stated the licensee was experiencing challenges when working with the resident case managers. LALD/CNS-A stated the support plans only go off what the case manager identifies as a resident need when they only visit the resident for approximately one hour per year, and the support plan choices allowed by case managers do not integrate well with the licensee's electronic medical record choices and will continue to work on their partnership with DHS. LALD/CNS-A verbalized when she completes the resident assessments and works with each resident on a regular basis she more accurately was able to assess service needs for the residents. Also, A-B stated when there is a change to a resident service need the licensee is told by the case manager that any changes that occur with the support plan will need to be made during the next evaluation period. A-B verbalized there are challenges in working with the case managers and trying to reconcile the residents' service plan with the DHS support plans. LALD/CNS-A and A-B stated they try their very best to accurately reflect the services to be provided for each resident and plan to continue to collaborate with the case managers as service needs change. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and	01880			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35094	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/02/2026
NAME OF PROVIDER OR SUPPLIER EAGLE GROUP HOME LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3414 OAKLAND 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
01880	Continued From page 25 substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to store refrigerated medication in a securely locked location and failed to monitor refrigeration temperatures for one of one resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R3 was admitted on May 21, 2024, and had diagnoses including bipolar disorder (a mental health disorder), attention deficit hyperactivity disorder (ADHD), anemia, multiple sclerosis (chronic disease that affects the central nervous system, which includes the brain, spinal cord, and optic nerves), and asthma. R3's signed provider orders dated June 2, 2026, indicated a start date of May 31, 2024, for Rebif (interferon beta 1a) (an injectable medication used to treat relapsing forms of multiple sclerosis), 44-0.5 milliliters (ml), inject 0.5 ml subcutaneously three times weekly. R3's Medication Administration Record (MAR)	01880			

Minnesota Department of Health

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01880	Continued From page 26 dated August 1, 2026, through August 31, 2026, indicated the above Rebif medication was administered as ordered. The Rebif Food and Drug Administration (FDA) prescriber information guide dated November 2021, indicated: "How should I store REBIF? -Store REBIF in the refrigerator between 36°F (Fahrenheit) to 46°F (2°C to 8°C). -Do not freeze REBIF. -If you cannot refrigerate your REBIF, you can store your REBIF at temperatures above 36°F and below 77°F (2°C to 25°C) for up to 30 days. -Keep REBIF away from heat and light." On August 31, 2026, at 10:40 a.m., during a tour, the surveyor observed an unlocked mini fridge located in the licensee's dining room. The mini fridge opened freely and contained three boxes and seven syringes of Rebif 44-05 ml. R3's name was on the prescription sticker affixed to the boxes. Additionally, there was no temperature gauge within the mini fridge, and no temperature log affixed to the refrigerator. Licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A observed the above and stated she knew medications should be securely locked, had not yet affixed a lock, and there was no way to verify the temperatures of the mini fridge. LALD/CNS-A further stated temperature logs should be recorded in the resident electronic health record, and all four residents of the home utilized this dining room area where the medication was stored. Unlicensed personnel (ULP)-C went into the kitchen, obtained the kitchen refrigerator thermometer and placed it in the medication mini-fridge in the dining room. On August 31, 2026, at 11:51 a.m., during a	01880			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER EAGLE GROUP HOME LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3414 OAKLAND AVENUE SOUTH MINNEAPOLIS, MN 55407			
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01880	Continued From page 27 follow up observation during the survey, the thermometer placed in the mini fridge was confirmed by LALD/CNS-A and surveyor to read 43 degrees F. The licensee's Storage/Control of Medications policy, dated December 1, 2025, indicated, "When [Licensee] is providing storage of medications outside of the resident's private living space, all prescription drugs are securely locked in substantially constructed compartments according to the manufacturer's directions. Only authorized personnel have access to the stored medications." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			



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

Food & Beverage Inspection Report

Page: 1

Establishment Info

EAGLE GROUP HOME LLC
3414 Oakland Ave S
Mineapolis, MN 55407
Hennepin County
Parcel:

Phone:

License Info

License: HFID 35094

Risk:
License:
Expires on:
CFPM: Abdulmalik Yusuf
CFPM #: 66431; Exp: 4/13/2029

Inspection Info

Report Number: F1063261253
Inspection Type: Full - Single
Date: 9/1/2026 Time: 1:00 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery:

No orders were issued for this inspection report.

Food & Beverage General Comment

Inspection was completed with MDH D. Hinnendael and S. Freking as the lead Health Regulation Division Nurse Evaluators completing the site survey.

Discussed highly susceptible populations, glove use, same day food service, food storage & temperature control, sanitizers, test kits, ware washing, animal prohibitions in food service areas, pest control, vomit cleanup procedures, and employee illness policy.

REFRIGERATOR TEMPERATURE: DELI TURKEY 39 DEGREES F

DISH MACHINE UTENSIL SURFACE TEMPERATURE: >160 DEGREES F

The facility has a residential kitchen. Food must be prepared for same day service only. The kitchen has paneled flooring, smooth painted walls & ceiling, smooth countertops, and wooden cabinetry. All facilities must be kept in good condition so that surfaces are smooth, durable, and easily cleanable.

Equipment includes a two-basin sink with one basin designated for handwashing, and ANSI residential fridge/freezer & dish machine.

Contact Health Regulation Division for plan review approval when facility/kitchen undergoes remodeling, major equipment additions, or changes of equipment due to a menu change.

If any customer complains of illness, establishment is required to notify the Minnesota Department of Health and provide the foodborne illness hotline phone number to the customer: 1-877-366-3455

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

I acknowledge receipt of the Metro District Office inspection report number F1063261253 from 9/1/2026

Chris Wright
Operator

Laura Yang,
Public Health Sanitarian 1
651-201-3581
laura.yang@state.mn.us

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL35094016-0	Date: September 3, 2026
Facility Name: Eagle Group Home LLC	
Facility Address: 3414 Oakland Ave, Minneapolis Minnesota 55407	

☒ TAG IDENTIFICATION: 0775

SCOPE/ SEVERITY: Level 2; IsolatedTIME PERIOD OF CORRECTION: Seven (7) days

1. A means of egress shall be free from obstructions that would prevent its use, including the accumulation of snow and ice. Means of egress shall remain free of any material or matter where its presence would obstruct or render the means of egress hazardous. No combustible material storage is allowed in the corridors or exit stairs. [Minn. Stat. 144G.45 subd. 2; MSFC 1031.3]
- Comments: Door for room number 3 had a padlock on the outside of the door (The lock was removed at the time of survey). Sidewalk on the side of the property was blocked by brush. Brush was growing inside the window well on the side of the property partially blocking egress window.

☒ TAG IDENTIFICATION: 0780

SCOPE/ SEVERITY: Level 2; WidespreadTIME PERIOD OF CORRECTION: Seven (7) days

1. Smoke alarms shall be interconnected so that actuation of one alarm causes all alarms in the individual dwelling or sleeping unit to operate where more than one smoke alarm is required within an individual dwelling or sleeping unit. [Minn. Stat. 144G.45 subd.2]
- Comments: Smoke alarms were not interconnected within the dwelling unit.

☒

 TAG IDENTIFICATION: 0800

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

1. The physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment are 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. [Minn. Stat. 144G.45 subd.2]

Comments: Light switch in dining room was in disrepair.