



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 7, 2024

Licensee

Eagle Group Home LLC

3414 Oakland Avenue South

Minneapolis, MN 55407

RE: Project Number(s) SL35094015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 17, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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 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.31, Subd. 4(a)(5), MDH may impose fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment. MDH may impose 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. MDH 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(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 survey:

0510 - 144g.41 Subd. 3 - Infection Control Program - \$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/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,



Jess Schoenecker, Supervisor

State Evaluation Team

Email: jess.schoenecker@state.mn.us

Telephone: 651-201-3789 Fax: 1-866-890-9290

JMD

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 07/17/2024
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: SL35094015-0 On July 15, 2024, through, July 17, 2024, 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 two residents; two receiving services under the provider's 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.		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 470	Continued From page 1 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 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 staffing plan was posted as required, potentially affecting the two residents in the assisted living facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 470			

Minnesota Department of Health

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0 470	Continued From page 2 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 15, 2024, at 12:00 p.m., the surveyor observed the main areas of the facility with administrator (AD)-B. The surveyor observed a posted "Employee Shift Schedule which included employee names, shift schedule, days of the week, and phone numbers. The shift schedule did not include the information for the employee working at the time of survey, unlicensed personnel (ULP)-C. On July 15, 2024, at 12:20 p.m., the surveyor observed ULP-C provide medication administration to one of the licensee's residents. On July 15, 2024, at 12:00 p.m., AD-B stated, via email, the licensee missed adding ULP-C to the daily staff schedule. Also, AD-B said the daily schedule was not updated or posted as required. On July 16, 2024, at 9:00 a.m., the surveyor observed the licensee had posted a document titled "07/15-07/21 -WEEK STAFF SCHEDULE," after the start of the survey, in the main area of facility that included the corrected employees scheduled to work for the week. On July 16, 2024, at 10:30 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee would ensure a current and accurate staff schedule was posted in the main area of the facility. The licensee's Staffing policy dated August 1,	0 470			

Minnesota Department of Health

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0 470	Continued From page 3 2021, included "5. A daily staffing schedule is prepared by the clinical nurse supervisor and addresses: -Home health aide work schedules for each home health aide showing all work shifts with days/hours worked; and -The home health aide ' s resident assignments or work location. Also, indicated "6. The schedule is posted at the beginning of the shift in a central location in each building, if applicable, accessible to staff, residents, volunteers and the public." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470			
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This 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	0 480			

Minnesota Department of Health

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0 480	Continued From page 4 or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated July 16, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
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 effective infection control program to comply with accepted health care, medical, and nursing standards for infection control when the	0 510			

Minnesota Department of Health

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0 510	Continued From page 5 licensee failed to ensure direct care staff performed adequate hand hygiene (HH) for one of one employee (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) 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: ULP-C was hired January 31, 2024, and provided direct care services to residents. On July 16, 2024, at 9:10 a.m., the surveyor observed ULP-C assisting R3 with medication administration. First, ULP-C donned (applied) gloves, unlocked the locked medication file cabinet, opened the electronic medical record on the laptop computer, and prepped R3's medications into medication cup. Next, ULP-C brought R3's medications to his room with a bottle of water, knocked on the door, and observed R3 take his oral medications. Next, R3 doffed (removed) gloves, placed gloves in the garbage container in the kitchen area, and documented R3's medications administered. Finally, ULP-C went up the stairs of the facility and began to vacuum. ULP-C did not complete hand hygiene prior to or after administering R3's medications. On July 16, 2024, at 9:20 a.m., ULP-C stated HH training was provided by licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A upon hire. LALD/CNS-A said ULP-C should have	0 510			

Minnesota Department of Health

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0 510	Continued From page 6 completed hand hygiene before and after R3's medication administration. On July 16, at 9:27 a.m., LALD/CNS-A stated the employees were trained to complete HH before and after completing medication administration, as well as at other points during clinical cares. Also, LALD/CNS-A verbalized training was completed upon hire and annually with all employees. The CDC guidance, CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, revised November 29, 2022, indicated, standard precautions were to be used to care for all patients in all settings to include HH, and noted, "Use an alcohol-based hand rub or wash with soap and water for the following clinical indications: a. Immediately before touching a patient b. Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices c. Before moving from work on a soiled body site to a clean body site on the same patient d. After touching a patient or the patient's immediate environment e. After contact with blood, body fluids or contaminated surfaces f. Immediately after glove removal." The licensee's Infection Control policy dated August 1, 2021, indicated, "Handwashing 1. All persons may be carriers of disease-producing microorganisms and therefore a possible source of infection. 2. Caring for residents requires the hands to be almost constantly touching the resident, articles of clothing and equipment used for care. 3. Hands should be washed at the	0 510			

Minnesota Department of Health

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0 510	Continued From page 7 following times: a. After changing beds b. Before assisting with medications c. Before and after treatments d. After all pet care e. After housekeeping f. After emptying bedpans g. After assisting the resident to the toilet h. After removing items from the floor i. Before preparing food j. Before feeding residents k. After using the bathroom l. After coughing or sneezing m. After smoking n. After handling plants o. After removing gloves." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language.	0 640			

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0 640	Continued From page 8 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post required content to include the 911 emergency number in common areas. This had the potential to 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 of the residents). The findings include: On July 15, 2024, at 11:48 a.m., the surveyor observed the main areas of the facility with administrator (AD)-B and unlicensed personnel (ULP)-C. The surveyor did not observe the 911 emergency number posted near two cordless telephones, one phone located on a countertop in the kitchen area, and the other phone located on a desk in the living room of the main floor of the facility. AD-B stated the cordless telephone could be used by staff, residents, or visitors. AD-B also stated she was unaware of the requirement for the 911 emergency number to be posted near the cordless telephone in the common areas and verbalized she would get the 911 emergency number posted. The licensee's Assisted Living License and Postings policy dated January 1, 2022, included "[Licensee] will maintain a current Assisted Living License issued by the Minnesota Department of Health. The issued license and other required	0 640			

Minnesota Department of Health

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0 640	Continued From page 9 postings will be posted within the facility." Also, indicated "7. [Licensee] shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640			
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (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:	0 660			

Minnesota Department of Health

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0 660	Continued From page 10 Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included TB baseline screening for one of two employees (registered nurse (RN-D)). 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 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: RN-D was hired on August 30, 2023, and provided direct nursing cares to the licensee's residents. On July 15, 2024, at 5:31 p.m., administrator (AD)-B provided, via email, RN-D's complete employee record. RN-D's employee record included a negative chest x-ray dated April 27, 2023, greater than 90-days prior to RN-D's hire date. RN-D's record lacked a timely TB baseline screening and written documentation of a previous positive TST or IGRA. On July 16, 2024, at 9:44 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she found yesterday RN-D's employee record did not include a timely TB screening including a missing documented	0 660			

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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0 660	Continued From page 11 positive initial TB screening test and documentation of a negative chest x-ray less than 90 days prior to her date of hire. LALD/CNS-A verbalized she planned to have RN-D complete the TB screening and place it in her record. The Minnesota Department of Health (MDH) guidelines, "Regulations for Tuberculosis Control in Minnesota Health Care Settings", dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include the following: a team responsible for TB infection control; a facility TB risk assessment; written TB infection control procedures; and HCW education. The guidelines also indicate an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients. Baseline TB screening should be documented in the employee's record." Also, indicated on page 13, "Before the HCW has direct patient contact, the following should be documented in their record: 1. Test result; 2. Assessment for current TB symptoms; 3. Chest X-ray to rule out infectious TB disease. The chest X-ray should be done after the date of the positive TST or IGRA; however, a chest X-ray done within the three months prior to the TST/IGRA is acceptable, provided that the HCW has not been exposed to infectious TB disease since the chest X-ray was done. If infectious TB disease is ruled out, additional chest X-rays are not needed unless the HCW develops symptoms of active TB disease or a clinician recommends a repeat chest X-ray; and 4. If the chest X-ray is done at the time of hire	0 660			

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0 660	Continued From page 12 because documentation of a previous film was not available, a medical evaluation to rule out infectious TB disease should be done. No medical evaluation is required if HCW already has a chest X-ray dated after documented positive TST or IGRA." The licensee's Tuberculosis Screening/Prevention policy dated August 1, 2021, 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 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 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." Also, included "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." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 660			

Minnesota Department of Health

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0 660	Continued From page 13 (21) days	0 660			
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 maintain fire extinguishers in accordance with MN Statute. This had the potential to affect all current 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 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). During facility tour on July 16, 2024, from approximately 11:30 a.m. through 12:00 p.m., with licensed assisted living director/clinical nurse	0 790			

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0 790	Continued From page 14 supervisor (LALD/CNS)-A, and administrator (AD)-B the surveyor observed that the fire extinguishers located in the main floor dining room and basement laundry room were dated 2022. Records were not available to show the fire extinguishers had received annual testing. Survey staff explained to LALD/CNS-A, and AD-B that the fire extinguishers are required to be annually replaced or provided annual certification tags to ensure all extinguishers are fully charged, and operable at their designated location. During the tour, LALD/CNS-A, and AD-B, verified the findings and stated that they understood the requirements. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790			
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation	0 810			

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0 810	Continued From page 15 plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a fire safety and evacuation plan with required content and failed to conduct the required training and drills. 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 potential to affect a large portion or all of the residents). The findings include: On July 16, 2024, at 12:10 p.m., licensed assisted living director/clinical nurse supervisor	0 810			

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0 810	Continued From page 16 (LALD/CNS)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee FSEP titled "Fire Safety", dated August 1, 2021, failed to include the following: The FSEP included standard employee procedures, but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but the plan was designed for a building with life safety systems such as manual fire alarms. The policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which did not have life safety systems stated in the policy. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. During an interview on July 16, 2024, at 12:40	0 810			

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0 810	Continued From page 17 p.m., LALD/CNS-A stated they understood the areas of the plan that needed to be updated. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. LALD/CNS-A provided documentation indicating that drills were conducted in February and May in 2024. This does not meet the requirement of every other month. During an interview on July 16, 2024, at 12:40 p.m., survey staff explained the requirements for frequency of drills. LALD/CNS-A stated they understood the requirements. TRAINING Record review indicated the licensee failed to provide evacuation training to residents at least once per year. LALD/CNS-A was unable to provide documentation showing any training offered or training scheduled for a future date for residents on the fire safety and evacuation plan. During an interview on July 16, 2024, at 12:40 p.m., survey staff explained the requirements for offering training to residents on the FSEP and evacuation procedures. LALD/CNS-A stated they understood the requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			

Type: Full
Date: 07/16/24
Time: 16:25:15
Report: 1018241096

Food and Beverage Establishment Inspection Report

Page 1

Location:

Eagle Group Home Llc
3414 Oakland Avenue South
Minneapolis, MN55407
Hennepin County, 27

Establishment Info:

ID #: 0038249
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6123543024
ID #:

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

The following orders were issued during this inspection.

4-700 Sanitizing Equipment and Utensils

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

MN Rule 4626.0900 Sanitize utensils and food contact surfaces of equipment before use, after cleaning. ESTABLISHMENT IS NOT CURRENTLY FOLLOWING THE 3 STEP SYSTEM FOR WASHING, RINSING AND SANITIZING. DISCUSSED WITH MANAGER TO OBTAIN BUCKETS FOR THIS PROCESS AND THE APPROPRIATE WAY TO WASH.

Comply By: 07/16/24

5-200C Plumbing: Maintenance, fixture location

5-205.11AB **** Priority 2 ****

MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing. DISCUSSED WITH MANAGER TO LABEL ONE SIDE OF 2 BASIN SINK AS HAND WASHING ONLY.

Comply By: 07/16/24

Food and Equipment Temperatures

Process/Item: Cold Holding

Temperature: 40 Degrees Fahrenheit - Location: REFRIGERATOR

Violation Issued: No

Type: Full
Date: 07/16/24
Time: 16:25:15
Report: 1018241096
Eagle Group Home Llc

Food and Beverage Establishment Inspection Report

Page 2

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

ESTABLISHMENT IS A RESIDENTIAL HOME WITH RESIDENTIAL EQUIPMENT.

FLOORS, WALLS AND CEILINGS WERE OBSERVED TO BE IN GOOD CONDITION DURING THIS INSPECTION AND WILL BE MONITORED THROUGH THE YEARS.

ESTABLISHMENT DOES ALL SAME DAY SERVICE OF FOOD.

KITCHEN HAS A TWO BASIN SINK, ONE OF WHICH WILL NOW BE USED STRICTLY FOR HAND WASHING.

DISCUSSED PEST CONTROL AND ILLNESS REPORTING.

VIEWED ILLNESS LOG.

INSPECTION CONDUCTED WITH DEDE HINNENDAEL (MDH) PRESENT.

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 1018241096 of 07/16/24.

Certified Food Protection Manager CANDACE A WRIGHT

Certification Number: FM119623 Expires: 11/04/26

Inspection report reviewed with person in charge and emailed.

Signed: _____

CHRISHUNA WRIGHT
MANAGER

Signed: _____

Rebecca Prestwood
Sanitarian 3
6512013777
rebecca.prestwood@state.mn.us