



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

September 10, 2025

Licensee

American Eagle Owatonna
334 Cedardale Drive Southeast
Owatonna, MN 55060

RE: Project Number(s) SL30559016

Dear Licensee:

On August 7, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on May 14, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Jodi Johnson'.

Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30559	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 08/07/2025
NAME OF PROVIDER OR SUPPLIER AMERICAN EAGLE OWATONNA			STREET ADDRESS, CITY, STATE, ZIP CODE 334 CEDARDALE DRIVE SE OWATONNA, MN 55060		
(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 FOLLOW UP SURVEY INITIAL COMMENTS SL30559016-1 On August 7, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on May 14, 2025. As a result of the follow-up survey, the licensee is in substantial compliance.	{0 000}			
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570;	{0 480}			

Minnesota Department of Health

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

TITLE

(X6) DATE

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{0 480}	Continued From page 1 (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by:	{0 480}			
{0 630} SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma	{0 630}	Not reviewed during this survey.		

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{0 630}	Continued From page 2 (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by:	{0 630}	Not reviewed during this survey.		
{0 650} SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living	{0 650}			

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{0 650}	Continued From page 3 services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by:	{0 650}	Not reviewed during this survey.		
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule.	{0 680}			

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{0 680}	Continued From page 4 This MN Requirement is not met as evidenced by:	{0 680}	Not reviewed during this survey.		
{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) staff 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) Staff of assisted living facilities shall receive training on the fire safety and evacuation 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 staff 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.	{0 810}			

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{0 810}	Continued From page 5	{0 810}			
	This MN Requirement is not met as evidenced by:		Not reviewed during this survey.		
{01370} SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family;	{01370}			

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{01370}	Continued From page 6 (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by:	{01370}	Not reviewed during this survey.		
{01380} SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by:	{01380}			

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{01500}	Continued From page 7	{01500}			
{01500} SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss.	{01500}			

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{01500}	Continued From page 8 Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by:	{01500}	Not reviewed during this survey.		
{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	{01620}			

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{01620}	Continued From page 9 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 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:	{01620}			
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{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:	{01640}	Not reviewed during this survey.		
{01700} SS=D	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided.	{01700}			

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{01700}	Continued From page 11 This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by:	{01700}	Not reviewed during this survey.		
{01730} SS=E	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication	{01730}			

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{01730}	Continued From page 12 management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by:	{01730}			
{01750} SS=E	144G.71 Subd. 7 Delegation of medication administration	{01750}	Not reviewed during this survey.		

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{01750}	Continued From page 13 When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by:	{01750}	Not reviewed during this survey.		
{01790} SS=D	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the	{01790}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30559	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 08/07/2025
NAME OF PROVIDER OR SUPPLIER AMERICAN EAGLE OWATONNA			STREET ADDRESS, CITY, STATE, ZIP CODE 334 CEDARDALE DRIVE SE OWATONNA, MN 55060		
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{01790}	Continued From page 14 unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication.	{01790}			

Minnesota Department of Health

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{01790}	Continued From page 15 This MN Requirement is not met as evidenced by:	{01790}	Not reviewed during this survey.		
{01940} SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced	{01940}			

Minnesota Department of Health

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{01940}	Continued From page 16 by:	{01940}	Not reviewed during this survey.		
{01970} SS=E	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by:	{01970}	Not reviewed during this survey.		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 8, 2025

Licensee

American Eagle Owatonna
334 Cedardale Drive Southeast
Owatonna, MN 55060

RE: Project Number(s) SL30559016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 14, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

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.

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

2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - \$3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$3,000.00**. 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

American Eagle Owatonna

July 8, 2025

Page 3

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,

A handwritten signature in black ink, appearing to read "Jodi Johnson", with a stylized flourish at the end.

Jodi Johnson, Supervisor

State Evaluation Team

Email: jodi.johnson@state.mn.us

Telephone: 507-344-2730 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30559	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/14/2025
NAME OF PROVIDER OR SUPPLIER AMERICAN EAGLE OWATONNA			STREET ADDRESS, CITY, STATE, ZIP CODE 334 CEDARDALE DRIVE SE OWATONNA, MN 55060		
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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: SL30559016-0 On May 12, 2025, through May 14, 2025, 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 17 residents; 17 receiving services under the Assisted Living Facility with Dementia Care license. 2310: An immediate order was issued on May 14, 2025, at a level 3/Widespread (I). The licensee took action on May 14, 2025; however, the scope and level remain at I.	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.		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30559	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/14/2025
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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480			

Minnesota Department of Health

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. 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 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 May 13, 2025, 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			

Minnesota Department of Health

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0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for two of three residents (R2 and 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: R2 R2 was admitted on February 29, 2024, with diagnoses that included heart failure and high blood pressure.	0 630			

Minnesota Department of Health

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0 630	Continued From page 4 R2's service plan dated July 24, 2024, indicated R2 received assistance with services to include hygiene/grooming, dressing, bathing, incontinence care, transfers, escorts, compression stockings, safety checks and medication administration. On May 13, 2025, at 8:41 a.m., the surveyor observed unlicensed personnel (ULP)-G administer medications to R2. R2's IAPP dated April 1, 2024, did not include the resident's risk of abusing other vulnerable adults. The IAPP indicated R2 was not susceptible to abuse from another individual, including other vulnerable adults. The licensee failed to recognize R2 was a vulnerable adult and was susceptible to abuse/neglect by others. Furthermore, the licensee failed to implement interventions to minimize abuse by others including other vulnerable adults. R3 R3 was admitted on April 25, 2024, with diagnoses that included heart failure and chronic obstructive pulmonary disease (COPD) (lung disease). R3's service plan dated July 24, 2024, indicated R3 received assistance with services to include bathing, hygiene/grooming, dressing, incontinence care, escorts, catheter care, eating assistance, safety checks, weights, vital signs and medication administration. On May 13, 2025, at 7:37 a.m., the surveyor observed ULP-G administer medications to R3. R3's IAPP dated July 9, 2024, indicated R3 was	0 630			

Minnesota Department of Health

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0 630	Continued From page 5 not susceptible to abuse from another individual, including other vulnerable adults. The licensee failed to recognize R3 was a vulnerable adult and was susceptible to abuse/neglect by others. Furthermore, the licensee failed to implement interventions to minimize R3's abuse by others including other vulnerable adults. On May 14, 2025, at 10:04 a.m., clinical nurse supervisor (CNS)-B reviewed R2 and R3's IAPP and stated all residents are considered vulnerable adults and susceptible to abuse, and their IAPP should have indicated they were at risk to be abused. CNS-B stated R2 was not at risk of abusing other vulnerable adults and it was an oversight that it was not addressed in R2's IAPP. The licensee's Individual Abuse Prevention Plan policy dated September 28, 2022, indicated the licensee will develop and implement an individual abuse prevention plan for each vulnerable adult. All residents in an assisted living are categorically considered vulnerable adults. 1 .The plan will contain and individualized review or assessment of the person's susceptibility to abuse by another individual, including: a. other vulnerable adults b. the person's risk of abusing other vulnerable adults, and c. statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults 2. For purposes of the abuse prevention plan, abuse includes self-abuse No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			

Minnesota Department of Health

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0 650	Continued From page 6	0 650			
0 650 SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records included all required content for two of three employees (unlicensed personnel (ULP)-D and ULP-G). 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	0 650			

Minnesota Department of Health

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0 650	Continued From page 7 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-D ULP-D was hired on March 8, 2023, to provide direct care services to the licensee's residents. On May 12, 2025, at 1:05 p.m., the surveyor observed ULP-D administer medications to R3. ULP-D's record lacked the following: - documentation of annual performance reviews that identify areas of improvement needed and training needs ULP-G ULP-G was hired on May 12, 2023, to provide direct care services to the licensee's residents. On May 13, 2025, at 7:37 a.m., the surveyor observed ULP-G administer medications R3. ULP-G's record lacked the following: - documentation of annual performance reviews that identify areas of improvement needed and training needs On May 14, 2025, at 10:53 a.m., licensed assisted living director (LALD)-A stated annual performance reviews could not be located for ULP-D and ULP-G. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One	0 650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30559	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/14/2025
NAME OF PROVIDER OR SUPPLIER AMERICAN EAGLE OWATONNA		STREET ADDRESS, CITY, STATE, ZIP CODE 334 CEDARDALE DRIVE SE OWATONNA, MN 55060			
(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
0 650	Continued From page 8 (21) days	0 650			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents, staff, and visitors of the facility.	0 680			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30559	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/14/2025
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0 680	Continued From page 9 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 Emergency Preparedness plan, undated, was reviewed and lacked the following: -conduct exercises to test EP at least twice per year, including unannounced staff drills using EP, including participating in an annual full-scale exercise community based or annual individual facility based functional exercise or if facility experiences an actual emergency requiring evacuation of plan, facility is exempt from engaging in its next required full scale exercise; conduct an additional annual exercise that may include a second full scale exercise community based or an individual; facility based functional exercise or mock disaster drill or table top exercise. On May 14, 2025, at 1:10 p.m., director of engineering (DOE)-F stated he believed the licensee had completed some of the required training but did not have documentation of the training and could not recall what topics were covered in the training. On May 14, 2025, at 1:25 p.m., licensed assisted living director (LALD)-A stated the EP plan lacked the required training as noted above. LALD-A stated she was in the process of updated the EP plan and scheduling the required training.	0 680			

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0 680	Continued From page 10 The licensee's Emergency Preparedness Plan-Appendix Z Compliance policy dated October 6, 2022, indicated the licensee will conduct, at minimum, two emergency preparedness drills every 12 months- these drills to not include required fire/evacuation drills. One annual exercise will be a full-scale community wide exercise. The second annual exercise will either be a second full-scale community-wide exercise, or a tabletop exercise focused on our assisted living setting. Exercises and drills will be designed to test our emergency plan and to identify gaps and areas for improvement. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
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) staff 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) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans	0 810			

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0 810	Continued From page 11 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 staff 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 observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content, provide the required training. 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: May 12, 2025, from 1:45 p.m. to 4:30 p.m., with licensed assisted living director (LALD)-A and director of engineering (DOE)-F; provided	0 810			

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0 810	Continued From page 12 documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. UNIQUE AND UNUSUAL RESIDENT NEEDS: The facility uses an electronic care plan website for standard resident evacuation procedures. The FSEP does not include instructions on how to use or what do in the loss of power/internet event for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. On May 12, 2025, at 2:30 p.m., LALD-A/DOE-F stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. The facility has different policies during several different directors since last survey. Current director has made establishing a FSEP a priority. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. LALD-A lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. Staff does web-based training at the time of hire, LALD-A stated they were using evacuation drills as training. No other training documentation was provided. On May 12, 2025, at 2:30 p.m., LALD-A/DOE-F stated they understood the requirements for training residents and staff and would implement a training program that was compliant with statute	0 810			

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0 810	Continued From page 13 requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy;	01370			

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01370	Continued From page 14 (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency was completed for one of three employees (unlicensed personnel (ULP)-G) to include all required content. 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-G was hired on May 12, 2023, to provide direct care services to the licensee's residents. On May 13, 2025, at 7:37 a.m., the surveyor observed ULP-G administer medications R3. ULP-G's employee record lacked evidence of training and/or competency for the following topics: -understanding appropriate boundaries between staff and residents and the resident's family; -appropriate and safe techniques in personal	01370			

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01370	Continued From page 15 hygiene and grooming including: -hair care and bathing -care of teeth, gums, and oral prosthetic devices -care and use of hearing aids -dressing and assistance with toileting -standby assistance techniques and how to perform them On May 14, 2025, at 10:06 a.m., clinical nurse supervisor (CNS)-B stated ULP-G lacked documentation of the training and/or competency evaluations as listed above. CNS-B stated the licensee was in the process of updating their training program and documents to ensure compliance with the required ULP training content. The licensee's Competency Training Evaluations policy dated September 27, 2022, indicated training and competency evaluation for all ULPs would include: -appropriate and safe techniques in person hygiene and grooming including: -hair care and bathing -care of teeth, gums, and oral prosthetic devices -care and use of hearing aids -dressing and assisting with toileting -standby assistance techniques and how to perform them -understanding appropriate boundaries between staff and residents and the resident's family No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370			

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01380	Continued From page 16	01380			
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency was completed for one of three employees (unlicensed personnel (ULP)-G) to include all required content. 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).	01380			

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01380	Continued From page 17 The findings include: ULP-G was hired on May 12, 2023, to provide direct care services to the licensee's residents. On May 13, 2025, at 8:41 a.m., the surveyor observed ULP-G administer medications to R2. ULP-G's employee record lacked evidence of competency evaluation for the following topics: -reading and recording temperature, pulse, and respirations of the resident; -safe transfer techniques and ambulation; -range of motion and positioning On May 14, 2025, at 10:06 a.m., clinical nurse supervisor (CNS)-B stated ULP-G lacked documentation of the competency evaluations as listed above. CNS-B stated the licensee was in the process of updating their training program and documents to ensure compliance with the required ULP training content. The licensee's Competency Training Evaluations policy dated September 27, 2022, indicated training and competency evaluation for all ULPs would include: -reading and recording temperature, pulse, and respirations of the resident -safe transfer techniques and ambulation -range of motion and positioning No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380			

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01500	Continued From page 18	01500			
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss.	01500			

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01500	Continued From page 19 Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for two of three employees (unlicensed personnel (ULP)-D and ULP-G). 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:	01500			

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01500	Continued From page 20 ULP-D ULP-D was hired on March 8, 2023, to provide direct care services to the licensee's residents. On May 12, 2025, at 1:05 p.m., the surveyor observed ULP-D administer medications to R3. ULP-D's employee record lacked evidence the employee had successfully completed annual training as required, to include the following: - Review of provider's policies and procedures ULP-G ULP-G was hired on May 12, 2023, to provide direct care services to the licensee's residents. On May 13, 2025, at 7:37 a.m., the surveyor observed ULP-G administer medications R3. ULP-G's employee record lacked evidence the employee had successfully completed annual training as required, to include the following: - Reporting maltreatment of vulnerable adults or minors - Review of provider's policies and procedures On May 14, 2025, at 1:30 p.m., licensed assisted living director (LALD)-A stated she would look for the above training in ULP-D and ULP-G's record and email the surveyor if it was found. On May 14, 2025, at 6:48 p.m., licensed assisted living director (LALD)-A emailed the surveyor documentation of ULP-D's review of the licensee's policies and procedures; however, it was dated March 8, 2023. LALD-A also emailed a certificate of completion dated May 17, 2023, for Preventing, Recognizing and Reporting Abuse and documentation of the review of the license's policies and procedures dated May 12, 2023.	01500			

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01500	Continued From page 21 These documents were completed during ULP-D and ULP-G's orientation and not part of annual training. The licensee's Annual Required Staff Training policy dated September 27, 2022, indicated the following training elements must be included every 12 months to all staff who perform direct care services: - Training on reporting of maltreatment of vulnerable adults under section 626.557 - Review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500			
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must	01620			

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NAME OF PROVIDER OR SUPPLIER AMERICAN EAGLE OWATONNA			STREET ADDRESS, CITY, STATE, ZIP CODE 334 CEDARDALE DRIVE SE OWATONNA, MN 55060		
(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
01620	Continued From page 22 be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing nursing assessments not to exceed 90 days for two of two residents (R1 and R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 R1 was admitted on July 18, 2024, with diagnoses that included diabetes. R1's service plan dated July 23, 2024, indicated R1 received assistance with services to include hygiene/grooming, escorts, safety checks, weights, vital signs and medication administration.	01620			

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01620	Continued From page 23 R1's ongoing nursing assessments dated August 6, 2024, November 17, 2024, and February 13, 2025, were reviewed. The November 17, 2024, assessment was completed 103 days after the date of the previous assessment, thus exceeding 90 calendar days. R2 R2's diagnoses included heart failure and high blood pressure. R2's service plan dated July 24, 2024, indicated R2 received assistance with services to include hygiene/grooming, dressing, bathing, incontinence care, transfers, escorts, compression stockings, safety checks and medication administration. R2's ongoing nursing assessments dated July 9, 2024, November 8, 2024, and February 12, 2025, were reviewed. The November 8, 2024, assessment was completed 122 days after the date of the previous assessment. The February 12, 2025, assessment was completed 96 days after the date of the previous assessment, thus both assessments exceeding 90 calendar days. On May 14, 2025, at 9:35 a.m., clinical nurse supervisor (CNS)-B stated R1 and R2's assessments were not completed within the required time frame as noted above. CNS-B stated the licensee had identified late assessments as an area in need of improvement and were working on a new process to ensure assessments were completed timely. The licensee's Assessments, Reviews and Monitoring policy dated September 27, 2022, indicated resident monitoring and review must be	01620			

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01620	Continued From page 24 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. 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 written	01640			

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01640	Continued From page 25 service plan was signed and revised to reflect the current services provided for three of three residents (R1, R2, and 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 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: R1 R1 was admitted on July 18, 2024, with diagnoses that included diabetes. R1's service plan dated July 23, 2024, indicated R1 received assistance with services to include hygiene/grooming, escorts, safety checks, weights, vital signs and medication administration. On May 13, 2025, at 7:57 a.m., the surveyor observed unlicensed personnel (ULP)-G check R1's blood sugar. R1's Medication Administration Record (MAR) dated May 2025, indicated R1's blood sugar was checked three times a day and as needed. R1's service plan did not include blood sugar checks and was not signed by R1 or R1's representative. R2	01640			

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01640	Continued From page 26 R2's diagnoses included heart failure and high blood pressure. On May 13, 2025, at 8:41 a.m., the surveyor observed ULP-G administer medications to R2. R2's service plan dated July 24, 2024, indicated R2 received assistance with services to include hygiene/grooming, dressing, bathing, incontinence care, transfers, escorts, compression stockings, safety checks and medication administration. R2's service plan was not signed by R2 or R2's representative. R3 R3 was admitted on April 25, 2024, with diagnoses that included heart failure and chronic obstructive pulmonary disease (COPD) (lung disease). R3's service plan dated July 24, 2024, indicated R3 received assistance with services to include bathing, hygiene/grooming, dressing, incontinence care, escorts, catheter care, eating assistance, safety checks, weights, vital signs and medication administration. On May 13, 2025, at 7:46 a.m., the surveyor observed ULP-G apply bilateral compression stockings to R3's lower extremities. R3's service plan did not include compression stockings and was not signed by R3 or R3's representative. On May 14, 2025, at 10:01 a.m., clinical nurse supervisor (CNS)-B reviewed R1, R2, and R3's service plans and stated R1 and R3's service	01640			

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01640	Continued From page 27 plans did not include all services provided as noted above. CNS-B stated R1, R2, and R3's service plans were not signed by the resident or residents' representative. The licensee's Service Plan policy dated September 28, 2022, indicated the service plan and any revisions shall include a signature or other authentication by the licensee and by the resident, or resident's representative, documenting agreement on the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
01700 SS=D	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent	01700			

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01700	Continued From page 28 diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of two residents (R2 and R3) who self-administered medications were assessed for self-administration of medications. 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: R2 R2's diagnoses included heart failure and high blood pressure. R2's service plan dated July 24, 2024, indicated R2 received assistance with medication administration. On May 13, 2025, at 8:41 a.m., the surveyor observed unlicensed personnel (ULP)-G	01700			

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01700	Continued From page 29 administer medications to R2. The surveyor noted a bottle of Tylenol (acetaminophen) on her bedside table. R2 stated she would take the Tylenol when she had pain in her stomach. R2 stated she also kept a bottle of Mylanta at her bedside to take for stomach pain, but the ULP took the bottle away the previous night. ULP-G stated she had removed the bottle of Mylanta from R2's bedside the night before because it was expired and told R2 she would have to get a new bottle. The surveyor also observed four individual eye drop containers on R2's bedside table. ULP-G stated R2 self-administered her eye drops. R2's record lacked prescriber orders for Mylanta. R2's Medication Administration Record (MAR) dated May 2025, indicated staff administered acetaminophen 1,000 milligrams (mg) to R2 every morning. R2's Medication Self-Administration Safety Screen dated February 1, 2025, indicated R1 could self-administer Refresh eye drops, all other medications were to be administered by staff. R2's Medication Management Plan dated November 8, 2024, indicated R2's medications were administered by staff. R3 R3 was admitted on April 25, 2024, with diagnoses that included heart failure and chronic obstructive pulmonary disease (COPD) (lung disease). R3's service plan dated July 24, 2024, indicated R3 received assistance with medication administration.	01700			

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01700	Continued From page 30 On May 13, 2025, at 7:37 a.m., the surveyor observed ULP-G administer medications to R3. The surveyor noted one bottle of Vitamin C and two bottles of Vitamin D3 on R3's bedside table. ULP-G stated R3 self-administered those medications. R3 stated his son recommended he take the vitamins and bought them for him. R3 stated he took one gummy from each bottle every day. R3's record lacked prescriber orders for the Vitamin C and Vitamin D3 gummies. R3's Medication Self-Administration Safety Screen dated November 8, 2024, indicated R3 was not able to self-administer medications. R3's Medication Management Plan dated February 12, 2025, indicated R3's medications were administered by staff. On May 14, 2025, at 9:56 a.m., clinical nurse supervisor (CNS)-B stated R2 was able to self-administer her eye drops only. CNS-B stated she was aware of the vitamins R3 had at his bedside table and would update R3's medication assessment to reflect R3's ability to self-administer the vitamins. CNS-B stated she was in the process of auditing and updating resident assessments as she was new the facility. The licensee's Medication Management-Assessment, Monitoring and Reassessment policy dated September 27, 2022, indicated the licensee would prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber conduct an assessment to determine what medication management services	01700			

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01700	Continued From page 31 will be provided and how the services will be provided. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700			
01730 SS=E	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to	01730			

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01730	Continued From page 32 documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized medication management plan with the required content for three of three residents (R1, R2, and 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 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: During the entrance conference on May 12, 2025, at approximately 10:00 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to the residents at the facility.	01730			

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01730	Continued From page 33 R1 R1 was admitted on July 18, 2024, with diagnoses that included diabetes. R1's service plan dated July 23, 2024, indicated R1 received assistance with medication administration. On May 13, 2025, at 8:00 a.m., the surveyor observed unlicensed personnel (ULP)-G remove one Lantus insulin pen from a locked refrigerator to prepare for administration to R1. ULP-G stated insulin pens are stored in the refrigerator until they are opened. R1's prescriber orders dated May 2, 2025, included the following: - Lantus Solostar Insulin 100 units/milliliter (ml); inject 65 units under the skin every morning - Insulin Lispro 100 unit/ml; Inject 15 units under the skin three times a day with meals R1's Medication Management Plan dated August 6, 2024, indicated the following: -medications were locked in a medication cart or in a locked medication room -The area that indicated "refrigerator or freezer in locked medication room per manufacturer" was left blank. R2 R2's diagnoses included heart failure and high blood pressure. R2's service plan dated July 24, 2024, indicated R2 received assistance with services to include medication administration. On May 12, 2025, at 1:08 p.m., the surveyor observed ULP-D remove a bottle of Deep Blue	01730			

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01730	Continued From page 34 Rub from R2's bedside drawer and apply it to R2's lower back. ULP-D put the Deep Blue Rub back in R2's bedside drawer. On May 13, 2025, at 9:26 a.m., the surveyor observed ULP-G administer medications to R2. The surveyor noted a bottle of Tylenol (acetaminophen) on her bedside table. R2 stated she would take the Tylenol when she had pain in her stomach. R2 stated she also kept a bottle of Mylanta at her bedside to take for stomach pain, but the ULP took the bottle away the previous night. ULP-G stated she had removed the bottle of Mylanta from R2's bedside the night before because it was expired and told R2 she would have to get a new bottle. The surveyor also observed four individual eye drop containers on R2's bedside table. ULP-G stated R2 self-administered her eye drops. R2's Medication Administration Record (MAR) dated May 2025, indicated staff administered acetaminophen 1,000 milligrams (mg) to R2 every morning. R2's prescriber orders included the following: -Refresh Tears 0.5% ophthalmic solution; place 1-2 drops in each eye at bedtime. Okay to keep in room and self-administer, order dated March 19, 2024 -acetaminophen 500 milligrams (mg); take two tablets (1,000 mg) by mouth once daily in the morning, order dated July 30, 2024 -Deep Blue Rub; apply to patient's lower back three times daily. Patient will supply medication, order dated July 30, 2024 R2's record lacked prescriber orders for Mylanta and additional Tylenol orders.	01730			

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01730	Continued From page 35 R2's Medication Management Plan dated November 8, 2024, indicated: - medications were locked in a medication cart in or a locked medication room - the community nurse or designee was responsible for monitoring supplies and ordering refills in a timely manner R3 R3 was admitted on April 25, 2024, with diagnoses that included heart failure and chronic obstructive pulmonary disease (COPD) (lung disease). R3's service plan dated July 24, 2024, indicated R3 received assistance with medication administration. On May 13, 2025, at 7:37 a.m., the surveyor observed ULP-G administer medications to R3. The surveyor noted one bottle of Vitamin C and two bottles of Vitamin D3 on R3's bedside table. ULP-G stated R3 self-administered those medications. R3 stated his son recommended he take the vitamins and bought them for him. R3 stated he took one gummy from each bottle every day. R3's record lacked prescriber orders for the Vitamin C and Vitamin D3 gummies. R3's Medication Management Plan dated February 12, 2025, indicated: - medications were administered by staff - medications were locked in a medication cart or in a locked medication room - the community nurse or designee was responsible for monitoring supplies and ordering refills in a timely manner	01730			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30559	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/14/2025
NAME OF PROVIDER OR SUPPLIER AMERICAN EAGLE OWATONNA			STREET ADDRESS, CITY, STATE, ZIP CODE 334 CEDARDALE DRIVE SE OWATONNA, MN 55060		
(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
01730	Continued From page 36 On May 14, 2025, at 9:57 a.m., clinical nurse supervisor (CNS)-B reviewed R1's medication plan and stated it should have included storage in the refrigerator as all insulin is stored there until they are opened. CNS-B reviewed R2's medication plan and stated R2 kept her eye drops and Deep Blue Rub at her bedside and family monitored and ordered the Deep Blue Rub which was not reflected in R2's medication plan. CNS-B reviewed R3's medication plan and stated R3's medication plan did not reflect accurately that R3 kept vitamins in his room, self-administered the vitamins and family monitored and ordered R3's vitamin supply. The licensee's Medication Management Individualized Plan policy dated September 28, 2022, indicated the licensee would develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: a. a statement describing the medication management services that will be provided b. a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions c. documentation of specific resident instructions relating to the administration of medications d. identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis e. identification of medication management tasks that may be delegated to unlicensed personnel f. procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services, and g. any resident-specific requirements relating to	01730			

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01730	Continued From page 37 documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
01750 SS=E	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse documented resident-specific instructions for three of three residents (R1, R2, and R3) whose medication administration was delegated to unlicensed personnel (ULP). 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	01750			

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01750	Continued From page 38 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: R1 R1 was admitted on July 18, 2024, with diagnoses that included diabetes. R1's service plan dated July 23, 2024, indicated R1 received assistance with medication administration. R1's prescriber order dated March 17, 2025, indicated: -Glucagon Emergency Kit 1 milligram (mg); inject 1 milliliter (ml) (1 mg total) intramuscularly once for one dose. R1's Medication Administration Record (MAR) dated May 2025, included the following: -Glucagon; inject 1 ml intramuscularly as needed for low blood sugar. First, try to bring up blood sugar by giving 15 grams of sugar every 15 minutes for three sets. If blood sugar does not rise, administer 1 ml of this medication. The licensee failed to have resident-specific instructions regarding what blood sugar result was considered a low blood sugar and would indicate administering glucagon to R1. R2 R2's diagnoses included heart failure and high blood pressure.	01750			

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01750	Continued From page 39 R2's service plan dated July 24, 2024, indicated R2 received assistance with medication administration. R2's prescriber order dated July 30, 2024, included the following: -Deep Blue Rub; apply to patient's lower back three times daily. Patient will supply medication R2's MAR dated May 2025, included the following: -Muscle Rub Cream; apply to lower back topically three times a day for pain (Deep Blue Rub) On May 12, 2025, at 1:08 p.m., the surveyor observed unlicensed personnel (ULP)-D apply a quarter size amount of Deep Blue Rub to R2's lower back. The surveyor inquired how ULP-D determined how much of the Deep Blue Rub to administer. ULP-D stated after administering the rub multiple times she knew the amount that would cover R2's lower back. R2's prescriber order and MAR failed to include the dose to administer for R2's Deep Blue Rub. R3 R3 was admitted on April 25, 2024, with diagnoses that included heart failure and chronic obstructive pulmonary disease (COPD) (lung disease). R3's service plan dated July 24, 2024, indicated R3 received assistance with medication administration. R3's prescriber order dated July 9, 2024, included: -diclofenac gel 1%; apply 2 grams (g) to bilateral	01750			

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01750	Continued From page 40 shoulders topically four times a day for pain R3's MAR dated May 2025, included the following: -diclofenac gel 1%; apply to both shoulders topically four times a day for pain in right and left shoulders. On May 13, 2025, at 7:46 a.m., the surveyor observed ULP-G apply a quarter size amount of diclofenac gel to R3's shoulders. The surveyor inquired how ULP-G determined the dose to administer of the diclofenac gel. ULP-G stated she used an amount that she thought would cover both of R3's shoulders. ULP-G stated if she used too much of the gel she would apply it to his upper back. ULP-G stated the MAR did not indicate a specific dose to administer. On May 14, 2025, at 9:50 a.m., clinical nurse supervisor (CNS)-B stated R1's order for glucagon did not indicate what was considered a low blood sugar for the glucagon to be administered. CNS-B stated if she felt R1 needed the glucagon injection, she would call the provider first to report her blood sugar results and then follow the provider direction. CNS-B stated R2 and R3's prescriber orders did not list the dose to administer as noted above. The licensee's Medication and Treatment-Administration and Delegation policy dated September 27, 2022, indicated a RN must specify, in writing, specific instructions for each resident and document those instructions in the residents' record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01750			

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01750	Continued From page 41 days	01750			
01790 SS=D	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to	01790			

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01790	Continued From page 42 be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) developed training and competencies for one of three unlicensed personnel (ULP-G) providing medications to residents for unplanned time away from home when the licensed nurse was not available. 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	01790			

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01790	Continued From page 43 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-G was hired on May 12, 2023, to provide direct care and services to the licensee's residents. ULP-G's employee record lacked documentation of training and competencies for unplanned time away when the RN was not available. On May 14, 2025, at 10:07 a.m., clinical nurse supervisor (CNS)-B stated ULP-G was trained, and competency tested on providing medications to residents for unplanned time away, but did not have documentation of the training or competencies. The licensee's Medication Management-Planned and Unplanned Time Away policy dated September 28, 2022, indicated for unplanned resident time away when a pharmacist or licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: 1. The registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790			

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01940	Continued From page 44	01940			
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for two of	01940			

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01940	Continued From page 45 three residents (R1 and 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: R1 R1 was admitted on July 18, 2024, with diagnoses that included diabetes. R1's service plan dated July 23, 2024, indicated R1 received assistance with services to include hygiene/grooming, escorts, safety checks, weights, vital signs and medication administration. The service plan did not include blood sugar checks. On May 13, 2025, at 7:57 a.m., the surveyor observed unlicensed personnel (ULP)-G check R1's blood sugar. R1's prescriber orders included the following: -Blood Sugar check three times a day with meals, order dated May 2, 2025 -Free Style Libre Sensor; replace sensor every 15 days, order dated May 9, 2025 R1's record lacked prescriber orders for daily blood pressure and pulse. R1's Medication Administration Record (MAR) dated May 2025, indicated the following:	01940			

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01940	Continued From page 46 - R1's blood sugar was checked three times a day and as needed. - R1's Free Libre Sensor (machine that checks blood sugar) was changed by staff every 15 days - Metoprolol 25 milligrams (mg); give 25 mg orally one time a day for blood pressure. Check blood pressure and hold if SBP (top number) is less than 100 or Pulse is less than 60. R1's record lacked a treatment management plan to include the following required content: - statement of the type of service that will be provided; - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; - procedures for notifying a registered nurse when a problem arose with treatments or therapy services; and - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed and monitoring of treatment or therapy to prevent possible complications or adverse reactions. R3 R3 was admitted on April 25, 2024, with diagnoses that included heart failure and chronic obstructive pulmonary disease (COPD) (lung disease). R3's service plan dated July 24, 2024, indicated R3 received assistance with services to include bathing, hygiene/grooming, dressing, incontinence care, escorts, catheter care, eating assistance, safety checks, weights, vital signs and medication administration. The service plan	01940			

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01940	Continued From page 47 did not include compression stockings. On May 13, 2025, at 7:46 a.m., the surveyor observed ULP-G apply bilateral compression stockings to R3's lower extremities. R3's prescriber order dated October 13, 2024, included the following order: -Knee high compression stockings. Put on in the morning upon waking, and take off at bedtime. R3's record lacked prescriber orders for daily pulse checks. R3's MAR dated May 2025, indicated the following: -Compression stockings; apply to both lower legs in the morning and remove per schedule. -Metoprolol 50 mg; give 50 mg orally one time a day. Check Pulse, hold for pulse less than 50 R3's Treatment and Therapy Plan dated May 7, 2024, failed to include the following: - statement of the type of service that will be provided; - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; - procedures for notifying a registered nurse when a problem arose with treatments or therapy services; and - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed and monitoring of treatment or therapy to prevent possible complications or adverse reactions.	01940			

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01940	Continued From page 48 On May 14, 2025, at 9:35 a.m., clinical nurse supervisor (CNS)-B reviewed R1 and R3's record and stated R1 and R3's record lacked an individualized treatment plans lacked the required content as noted above. CNS-B stated she was updating resident assessments with their upcoming 90-day assessments as she identified that resident assessments was an area that needed improvement. The licensee's Treatment and Therapy Management Plan policy dated September 27, 2022, indicated a current individualized treatment and therapy management record for each resident which must contain at least the following: a. a statement of the type of services that will be provided b. documentation of specific resident instructions relating to the treatments or therapy administration c. identification of treatment or therapy tasks that will be delegated to unlicensed personnel d. procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services e. any resident-specific requirements relating to documentation of treatments and therapy received f. verification that all treatment and therapy was administered as prescribed g. monitoring of treatment or therapy to prevent possible complications or adverse reactions No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940			

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01970	Continued From page 49	01970			
01970 SS=E	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for three of three residents (R1, R2, and R3) receiving treatments. 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: R1 R1 was admitted on July 18, 2024, with diagnoses that included diabetes. R1's service plan dated July 23, 2024, indicated R1 received assistance with services to include hygiene/grooming, escorts, safety checks, weights, vital signs and medication	01970			

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NAME OF PROVIDER OR SUPPLIER AMERICAN EAGLE OWATONNA			STREET ADDRESS, CITY, STATE, ZIP CODE 334 CEDARDALE DRIVE SE OWATONNA, MN 55060		
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01970	Continued From page 50 administration. The service plan did not include blood sugar checks. On May 13, 2025, at 8:10 a.m., the surveyor observed unlicensed personnel (ULP)-G check R1's blood pressure and pulse. R1's record lacked prescriber orders for daily blood pressure and pulse. R1's Medication Administration Record (MAR) dated May 2025, indicated the following: -Metoprolol 25 milligrams (mg); give 25 mg orally one time a day for blood pressure. Check blood pressure and hold if SBP (top number) is less than 100 or Pulse is less than 60. R2 R2's diagnoses included heart failure and high blood pressure. On May 13, 2025, at 8:41 a.m., the surveyor observed ULP-G offer to apply compression stockings to R2's lower extremities. R2 declined to wear the compression stockings. R2's service plan dated July 24, 2024, indicated R2 received assistance with services to include hygiene/grooming, dressing, bathing, incontinence care, transfers, escorts, compression stockings, safety checks and medication administration. R2's record lacked prescriber orders for compression stockings. R2's Service Provided Document dated May 2025, indicated staff applied compression stockings every morning and removed them at bedtime.	01970			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30559	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/14/2025
NAME OF PROVIDER OR SUPPLIER AMERICAN EAGLE OWATONNA			STREET ADDRESS, CITY, STATE, ZIP CODE 334 CEDARDALE DRIVE SE OWATONNA, MN 55060		
(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
01970	Continued From page 51 R3 R3 was admitted on April 25, 2024, with diagnoses that included heart failure and chronic obstructive pulmonary disease (COPD) (lung disease). R3's service plan dated July 24, 2024, indicated R3 received assistance with services to include bathing, hygiene/grooming, dressing, incontinence care, escorts, catheter care, eating assistance, safety checks, weights, vital signs and medication administration. The service plan did not include compression stockings. On May 13, 2025, at 7:43 a.m., the surveyor observed ULP-G check R3's pulse. R3's record lacked prescriber orders for daily pulse checks. R3's MAR dated May 2025, indicated the following: -Metoprolol 50 mg; give 50 mg orally one time a day. Check Pulse, hold for pulse less than 50 On May 14, 2025, at 9:43 a.m., clinical nurse supervisor (CNS)-B stated R1, R2 and R3's record lacked prescriber orders for the treatments noted above. CNS-B stated she had contacted R1, R2 and R3's providers to obtain treatment orders. The licensee's Medication and Treatment Orders policy dated September 28, 2022, indicated residents who receive medication management services by [licensee name] will have a current physician prescribed medication or treatment/therapy orders on record. Medication	01970			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30559	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/14/2025
NAME OF PROVIDER OR SUPPLIER AMERICAN EAGLE OWATONNA			STREET ADDRESS, CITY, STATE, ZIP CODE 334 CEDARDALE DRIVE SE OWATONNA, MN 55060		
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01970	Continued From page 52 and treatment orders must be renewed at least every 12 months or more frequently as required. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970			
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure care and services were provided according to acceptable health care and medical or nursing standards for the licensee's one resident (R2) with bed rails. This resulted in an immediate correction order issued on May 14, 2025. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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:	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30559	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/14/2025
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02310	Continued From page 53 R2's diagnoses included heart failure and high blood pressure. R2's service plan dated July 24, 2024, indicated R2 received assistance with services to include hygiene/grooming, dressing, bathing, incontinence care, transfers, escorts, compression stockings, safety checks and medication administration. On May 13, 2025, at 8:41 a.m., the surveyor observed R2's bed to have a rectangle shaped bedrail, which was secured on the right side of the bed. R2 stated she used the bedrail to assist with getting in and out of bed and repositioning. R2's Treatment and Therapy Plan dated July 18, 2024, indicated R2 utilized a bed rail on the right side of her bed. R2's undated and incomplete, Bed Rail Positioning Device assessment indicated R2 used a half side rail for turning and repositioning in bed. R2's record lacked: - a complete assessment for the current bed rail use; - evidence of risk vs. benefits education on bed rail use with R2 or R2's responsible party; - evidence R2's bed rail was used, installed, and maintained per manufacturer's instructions; and - evidence R2's bed rail was checked for recalls with the Consumer Product Safety Commission (CPSC). On May 14, 2025, at 10:12 a.m., the surveyor reviewed R2's Bed Rail Positioning Device assessment with clinical nurse supervisor (CNS)-B and licensed assisted living director	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30559	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/14/2025
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02310	Continued From page 54 (LALD)-A. CNS-B confirmed the assessment was not completed with many areas left blank. CNS-B stated the assessment was done by a previous nurse who no longer worked for the licensee. CNS-B stated R2's record did not include a complete assessment for the bed rail, documentation of risks vs. benefits education discussion with R2 or R2's representative, documentation the bed rail was used, installed, and maintained per manufacturer's instructions or documentation the bed rail was checked for recalls with CPSC. The licensee's Side Rails policy dated October 12, 2022, indicated the following: When [licensee name] is aware a home care resident is utilizing side rails (a medical device) on a bed, [licensee name] will assess the use, educate the resident, and when appropriate, the responsible person, regarding the risks and benefits of side rails, and verify that the side rail in use is of a safe design and utilized consistent with the manufacturer's directions. This policy shall be followed regardless of who owns or is supplying the side rail. The FDA, "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe".	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30559	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/14/2025
NAME OF PROVIDER OR SUPPLIER AMERICAN EAGLE OWATONNA			STREET ADDRESS, CITY, STATE, ZIP CODE 334 CEDARDALE DRIVE SE OWATONNA, MN 55060		
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02310	Continued From page 55 The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE On May 14, 2025, the license implemented	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30559	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/14/2025
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02310	Continued From page 56 actions to mitigate the risk to R2. Scope and severity remain at I.	02310			



Rochester District Office
Minnesota Department of Health
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Phone: 651-201-4500

Food & Beverage Inspection Report

Page: 1

Establishment Info

American Eagle Owatonna
334 Cedardale Drive SE
Owatonna, MN 55060
Steele County
Parcel:

Phone: 507-446-8600
bblouin@timberdaletrace.org

License Info

License: HFID 30559
Brittnay Blouin
Risk:
License:
Expires on:
CFPM:
CFPM #: ; Exp:

Inspection Info

Report Number: F8044251014
Inspection Type: Full - Single
Date: 5/13/2025 Time: 8:12:07 AM
Duration: 60 minutes
Announced Inspection: Yes
Total Priority 1 Orders: 1
Total Priority 2 Orders: 1
Total Priority 3 Orders: 1
Delivery: Emailed

! New Order: 2-300 Personal Cleanliness

2-301.14B-G *Priority Level: Priority 1 CFP#: 8*

MN Rule 4626.0075B-G Food employees must wash their hands after: using the toilet; coughing or sneezing; using a handkerchief or disposable tissue; using tobacco; eating or drinking; handling soiled equipment or utensils; caring for or handling service animals or fish in an aquarium, molluscan shellfish or crustacea in a display tank; as frequently as necessary during food preparation to remove soil, contamination, and to prevent cross-contamination when changing food preparation tasks; when switching between working with raw food and working with RTE food; before donning gloves for working with food; and touching bare human body parts other than clean hands and clean exposed portions of arms.

COMMENT: Observed staff don gloves without first washing hands.

Hands washed upon request.

Comply By: 5/13/2025 Originally Issued On: 5/13/2025

New Order: 5-200C Plumbing: Maintenance, fixture location

5-205.11AB *Priority Level: Priority 2 CFP#: 10*

MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.

COMMENT: Observed staff use handwashing sink to fill water for oatmeal, rather than using prep sink.

Comply By: 5/13/2025 Originally Issued On: 5/13/2025

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A *Priority Level: Priority 3 CFP#: 55*

MN Rule 4626.1520A Clean and maintain all physical facilities clean.

COMMENT: Dirt and debris beneath stainless steel cabinets.

Comply By: 5/13/2025 Originally Issued On: 5/13/2025

Food & Beverage General Comment

HRD inspection conducted with nurse evaluator Kassie Marking. Report reviewed on site with Brittany Blouin.

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 Rochester District Office inspection report number F8044251014 from 5/13/2025

Brittnay Blouin
Director of Dining Services

Michael DeMars,
Public Health Sanitarian III
507-206-2715
michael.demars@state.mn.us



Rochester District Office
Minnesota Department of Health
3425 40th Avenue NW, Suite 115
Rochester, MN 55901

Temperature Observations/Recordings

Page: 1

Establishment Info

American Eagle Owatonna
Owatonna
County/Group: Steele County

Inspection Info

Report Number: F8044251014
Inspection Type: Full
Date: 5/13/2025
Time: 8:12:07 AM

Food Temperature: **Product/Item/Unit:** Cole slaw; **Temperature Process:** Cold-Holding

Location: Upright Cooler at 36.4 Degrees F.

Comment:

Violation Issued?: No

Equipment Temperature: **Product/Item/Unit:** ; **Temperature Process:** Cold-Holding

Location: Upright Cooler at 35.0 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** Sausage links; **Temperature Process:** Re-Heating (commercial)

Location: Grill at 163.8 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** French toast; **Temperature Process:** Hot-Holding

Location: Grill at 167.7 Degrees F.

Comment:

Violation Issued?: No



Rochester District Office
Minnesota Department of Health
3425 40th Avenue NW, Suite 115
Rochester, MN 55901

Sanitizer Observations/Recordings

Establishment Info	Inspection Info
American Eagle Owatonna	Report Number: F8044251014
Owatonna	Inspection Type: Full
County/Group: Steele County	Date: 5/13/2025
	Time: 8:12:07 AM

Sanitizing Equipment: Product: Hot Water; **Sanitizing Process:** Dish Machine
Location: Kitchen **Equal To** 167.2 Degrees F.
Comment:
Violation Issued?: No

Minnesota (MDH) Version EH Manager; RPT: F8044251014		Food Establishment Inspection Report		Page 1 of 1	
 Rochester District Office Minnesota Department of Health 3425 40th Avenue NW, Suite 115 Rochester, MN 55901		No. of Risk Factor/Intervention/Violations		2	Date: 5/13/2025
		No. of Repeat Risk Factor/Intervention/Violations			Time: 8:12:07 AM
		Score (optional)			Dur: 60 min
Establishment: American Eagle Owatonna		Address: 334 Cedardale Drive SE		City/State: Owatonna, MN	Zip: 55060
License/Permit #: HFID 30559		Permit Holder:		Purpose of Inspection: Full	Est. Type: Risk Category:
FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS					
Designated compliance status (IN, OUT, N/O, N/A) for each numbered item					
IN=in compliance OUT=not in compliance N/O=not observed N/A=not applicable					
Mark "X" in appropriate box for COS and/or R					
COS=corrected on-site during inspection R=repeat violation					
Compliance Status				COS	R
Supervision					
1	IN	Person in charge present, demonstrate knowledge and performs duties			
2	IN	Certified Food Protection Manager			
Employee Health					
3	IN	knowledge, responsibilities, and reporting			
4	IN	Proper use of restriction and exclusion			
5	IN	Response to vomiting, diarrheal events			
Good Hygienic Practices					
6	IN	Proper eating, tasting, drinking, tobacco use			
7	IN	No discharge from eyes, nose, and mouth			
Preventing Contamination by Hands					
8	OUT	Hands clean and properly washed			
9	IN	No bare hand contact with RTE foods, alternatives			
10	OUT	Adequate handwashing sinks supplied and access			
Approved Source					
11	IN	Food obtained from approved source			
12	N/O	Food Received at proper temperature			
13	IN	Food in good condition, safe & unadulterated			
14	N/A	Records available: shellstock tags, parasite dest.			
Protection From Contamination					
15	IN	Food separated and protected			
16	IN	Food-contact surfaces; cleaned & sanitized			
17	IN	Proper Disposition of returned, previously served, reconditioned, & unsafe food			
GOOD RETAIL PRACTICES					
Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.					
Mark "X" or OUT in box if numbered item is not in compliance Mark "X" in appropriate box for COS and/or R COS=corrected on-site during inspection R=repeat violation					
Compliance Status				COS	R
Safe Food and Water					
30	IN	Pasteurized eggs used where required			
31		Water & ice from approved source			
32	IN	Variance obtained for specialized processing methods			
Food Temperature Control					
33		Proper cooling methods used; adequate equipment for temperature control			
34	N/O	Plant food properly cooked for hot holding			
35	N/O	Approved thawing methods used			
36		Thermometers provided & accurate			
Food Identification					
37		Food properly labeled; original container			
Prevention of Food Contamination					
38		Insects, rodents, & animals not present; no unauthorized person			
39		Contamination prevented during food prep, storage, & display			
40		Personal cleanliness			
41		Wiping cloths: properly used & stored			
42		Washing fruits & vegetables			
Person in Charge (signature)					
Inspector (signature)					
Follow-up: Follow-up Date:					
Time/Temperature Control for Safety					
18	N/O	Proper cooking time & temperatures			
19	IN	Proper reheating procedures for hot holding			
20	N/O	Proper cooling time and temperature			
21	IN	Proper hot holding temperatures			
22	IN	Proper cold holding temperatures			
23	IN	Proper date marking & disposition			
24	N/A	Time as public health control; procedures & record			
Consumer Advisory					
25	N/A	Consumer advisory provided for raw or undercooked foods			
Highly Susceptible Populations					
26	IN	Pasteurized foods used; prohibited foods not offered			
Food/Color Additives and Toxic Substances					
27	N/A	Food additives; approved & properly used			
28	IN	Toxic substances properly identified; stored; used			
Conformance with Approved Procedures					
29	N/A	Compliance with variance, specialized processes & HACCP plan			
Risk factors are improper practices or procedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health interventions are control measures to prevent foodborne illness or injury					