Electronically Delivered

July 17, 2026

Licensee
Open Arms Housing Inc
6250 Rainbow Drive Northeast
Fridley, MN 55432

RE: Project Number(s) SL36590016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 16, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00
St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,000.00**. 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 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.

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,

Kelly Thorson

Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36590	A. BUILDING: _____ B. WING _____	06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS HOUSING INC	6250 RAINBOW DRIVE NE FRIDLEY, MN 55432

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL36590016-0 On June 15, 2026, through June 16, 2026 the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were three (3) residents; three (3) receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) reviewed the staffing plan at least twice per year. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	0 470		

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0 470	Continued From page 2 cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living license and was licensed for a capacity of five residents, with a current census of three residents. The licensee's 24 Daily Staffing Schedule dated June 14, 2026, through June 20, 2026, indicated one staff available 24 hours a day. The staffing plan lacked documentation it had been evaluated at least twice per year to determine the appropriateness of staffing levels in the facility. On June 15, 2026, at 12:15 p.m., owner/unlicensed personnel (O/ULP)-A stated the staffing schedule is the staffing plan, but she does not have evidence it has been reviewed twice annually and was not aware of this staffing plan requirement. The licensee's 4.06 Staffing and Scheduling policy dated August 1, 2021, indicated the clinical nurse supervisor will develop and implement a written staffing plan that provides an adequate number of qualified direct-care staff to meet the residents' needs 24-hours a day, seven days a week. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		

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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; (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	0 480		

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0 480	Continued From page 4 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: 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, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated June 15, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24	0 480		

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0 480	Continued From page 5 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
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 develop a written emergency preparedness plan (EPP) with all the required	0 680		

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0 680	Continued From page 6 content. This had the potential to affect all residents, employees, and visitors to the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: The licensee's EPP dated August 21, 2024, lacked the required content: - annual review; - a quarterly review of missing resident policy; - identify program patient population; - the development of policies/procedures to address: - arrangement with other facilities; - a communication plan that included: - names and contact information for staff, entities providing services, resident physicians, other facilities, and volunteers; - emergency official contact information; and - documentation EPP exercise has been tested twice a year. On June 16, 2026, at 9:00 a.m., owner/unlicensed personnel (O/ULP)-A stated she agrees some of the required pieces of the EPP are missing, she agreed an annual review had not been completed, the missing person policy had not been reviewed quarterly, she does not have a memorandum of understanding with another provider in case of an evacuation situation, and does not have evidence of two drills completed annually.	0 680		

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0 680	Continued From page 7 The licensee's 9.01 Emergency Preparedness Plan - Appendix Z Compliance policy dated August 1, 2021, indicated licensee's emergency preparedness plan will include all required elements of appendix Z. The plan will be in writing and reviewed annually. The licensee's 2.28 Missing Resident policy dated August 1, 2021, indicated the licensee will review this policy and any individual resident plans that pertain to elopement at least quarterly, and all changes will be documented. Per Assisted Living Facilities: Minnesota Rules Chapter 4659, 4659.0110, Subp. 4. Review missing resident plan. The assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota	0 775		

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0 775	Continued From page 8 Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated June 16, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: SEVEN (7) days.	0 775		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by:	0 800		

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0 800	Continued From page 9 Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated June 16, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: SEVEN (7) days.	0 800		
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	0 810		

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0 810	Continued From page 10 (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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic	0 810		

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0 810	Continued From page 11 failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated June 16, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: SEVEN (7) days.	0 810		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the	01060		

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	36590	A. BUILDING: _____ B. WING _____	06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS HOUSING INC	6250 RAINBOW DRIVE NE FRIDLEY, MN 55432

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01060	Continued From page 12 resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation for one of one resident (R1). 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:	01060		

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01060	Continued From page 13 R1 was admitted to the licensee on January 18, 2021, with diagnoses which included schizo-affective disorder, anxiety, constipation and trouble sleeping. R1's record indicated R1 was hospitalized on May 19, 2026, through June 3, 2026, for mood stabilization, improved thinking, schizophrenia treated and problems related to your primary psychiatric condition treated. R1's record lacked a written notice provided to R1 which included: - the reason for relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. - this notice must be delivered as soon as practicable to: - the resident, legal representative, and designate representative; - the resident's case manager; and -notify Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days.	01060		

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01060	Continued From page 14 On June 16, 2026, at 10:53 a.m., owner/unlicensed personnel (O/ULP)-A stated she did not provide an emergency relocation notification for R1's hospitalization and did not update the Ombudsman after R1 had been gone for four days and was not aware of this statute requirement. On June 16, 2026, at 1:20 p.m., clinical nurse supervisor (CNS)-B stated she was not aware of the emergency relocations notification requirements. The licensee's 1.23 Emergency Relocations policy, dated August 1, 2021, indicated In the event of an emergency relocation, licensee will provide a written notice that contains, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated in any new service provider; - contact information for the Office of Ombudsman for Long-Term Care; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and - a statement that, if the facility refuses to provide housing or services after relocation, the resident has the right to appeal. The notice required will be delivered as soon as practicable to: - the resident, legal representative, and designated representative; - where residents who receive home and community-based waiver services, the residence case manager; and - the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not	01060		

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01060	Continued From page 15 returned to the facility within four days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01500 SS=F	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	01500		

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01500	Continued From page 16 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. 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 two employees (owner/unlicensed personnel (O/ULP)-A and unlicensed personnel ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive	01500		

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01500	Continued From page 17 or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: O/ULP-A On June 15, 2026, at 10:20 a.m. and again at 10:50 a.m., the surveyor observed O/ULP-A administer medications to residents (R1 and R2). O/ULP-A had an employment date of March 11, 2020, and started providing assisted living services on August 1, 2021. ULP-C ULP-C was hired by the licensee on July 11, 2024, to provide assisted living services to residents. O/ULP-A and ULP-C's employee records both lacked evidence of annual training had been completed as required in the following areas: - Effective approaches to use to solve problems when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders. On June 16, 2026, at 3:15 p.m., O/ULP-A stated the annual training topic of effective approaches to use to solve problems when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders has not been completed by any of the staff because they were using other dementia training to fulfill the two hour annual requirement and not this particular topic.	01500		

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01500	Continued From page 18 The licensee's 5.06 Annual Required Staff Training policy dated August 1, 2021, indicated the following training methods must be included every 12 months to all staff who performs direct care services: - Effective approaches to use to solve problems when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under	01530		

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01530	Continued From page 19 paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct care staff received the required two (2) hours of initial training on mental illness and de-escalation topics within 160 hours of start date for two of two employees (owner/unlicensed personnel (O/ULP)-A and unlicensed personnel (ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	01530		

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01530	Continued From page 20 The findings include: O/ULP-A On June 15, 2026, at 10:20 a.m. and again at 10:50 a.m., the surveyor observed O/ULP-A administer medications to residents (R1 and R2). O/ULP-A had an employment date of March 11, 2020, and started providing assisted living services on August 1, 2021. ULP-C ULP-C was hired by the licensee on July 11, 2024, to provide assisted living services to residents.. O/ULP-A and ULP-C's personnel records both lacked the required two hours of inital mental illness and de-escalation training within 160 hours of working for the licensee. On June 16, 2026, at 3:15 p.m., O/ULP-A stated the mental illness and de-escalation training was not completed due to not being aware of the new requirement and none of the employees would have any of this training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01720 SS=D	144G.71 Subd. 4 Resident refusal The assisted living facility must document in the resident's record any refusal for an assessment for medication management by the resident. The facility must discuss with the resident the possible	01720		

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	36590	A. BUILDING: _____ B. WING _____	06/16/2026

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01720	Continued From page 21 consequences of the resident's refusal and document the discussion in the resident's record. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to discuss with the resident the possible consequences of the resident's medication refusal and document the discussion in the resident's record for one of one (R2) reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted to the licensee on March 4, 2025, with diagnoses which included schizo-affective disorder, nicotine addiction, post amputation of finger pain, and constipation. R2's signed service plan dated March 4, 2026, indicated R2 received medication administration services. R2's Medication Administration Record (MAR) dated May 1, 2026, through May 31, 2026, indicated R2 had refused the nicotine patch 7mg medication 22 of the 31 days. R2's MAR dated June 1, 2026, through June 16, 2026, indicated R2 had refused the nicotine patch 7mg medication 16 of the 16 days. The MAR indicated	01720		

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	36590	A. BUILDING: _____ B. WING _____	06/16/2026

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01720	Continued From page 22 the reason for refusal was resident refused. R2's record lacked documentation of discussion and education provided to R2 on possible consequences of the refusal of medications, or updates to the provider regarding the missed medications. On June 16, 2026, at 12:40 p.m., owner/unlicensed personnel (O/ULP)-A stated she agrees the nurse has not documented any follow up completed with the resident on his refusals of the nicotine patch or with the provider to advise of the refusals and see about a change in the order. On June 16, 2026, at 1:20 p.m., clinical nurse supervisor (CNS)-B stated the follow up on the nicotine patch refusals was on her to do list, however, it keeps getting pushed off and has not been completed yet, but she agrees she should update the provider to get a new order. The licensee's 7.22 Medication and Treatment Record - Documentation and Refusal policy dated August 1, 2021, indicated the facility must discuss with the resident the possible consequences of the resident's refusal and document the discussion in the residence record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01720		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted	01760		

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01760	Continued From page 23 living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prescriber orders were transcribed for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On June 15, 2026, at 10:50 a.m., the surveyor observed owner/unlicensed personnel (O/ULP)-A administer medications to R2. R2 was admitted to the licensee on March 4, 2025, with diagnoses which included schizo-affective disorder, nicotine addiction, post	01760		

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01760	Continued From page 24 amputation of finger pain, and constipation. R2's signed service plan dated March 4, 2026, indicated R2 received medication administration services. R2's signed prescriber orders dated April 24, 2026, included: - diphenhydramine (Benedryl) HCL 25 milligram (mg) take one tablet, up to three times a day, as needed for anxiety or agitation. R2's medication administration records (MAR) dated May 1, 2026, through May 31, 2026, and June 1, 2026, through June 15, 2026, lacked the medication diphenhydramine. On June 16, 2026, at 12:40 p.m., O/ULP-A stated she agrees there is a signed order for Benadryl, but it is not on the MAR. On June 16, 2026, at 1:20 p.m., clinical nurse supervisor (CNS)-B stated the Benadryl was a transcription error and was an oversight on her part. The licensee's 7.16 Medication and Treatment Orders-Implementing policy dated August 1, 2021, indicated Upon receipt of a medication and/or treatment order, whether new or change of an order from an authorized prescriber, A licensed nurse must take action to implement the order within 24 hours. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		

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01820	Continued From page 25	01820		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On June 15, 2026, at 10:20 a.m., the surveyor observed owner/unlicensed personnel (O/ULP)-A administer medications to R1. R1 was admitted to the licensee on January 18, 2021, with diagnoses which included schizo-affective disorder, anxiety, constipation and trouble sleeping. R1's Service Plan dated May 22, 2026, indicated R1 received services which included medication administration.	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36590	A. BUILDING: _____ B. WING _____	06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS HOUSING INC	6250 RAINBOW DRIVE NE FRIDLEY, MN 55432

(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
01820	Continued From page 26 R1's medication administration record (MAR) dated June 1, 2026, through June 15, 2026, included the following medications: - aripiprazole 20 milligrams (mg), take one tablet by mouth daily for schizophrenia; - ceravite senior daily multivitamin, take one tablet by mouth every morning for nutritional support; - clozapine 200 mg tablet, take one tablet by mouth every morning and take two tablets every night at bedtime forschizophrenia; - vitamin D3 25 micrograms(mcg), take one capsule by mouth daily for vitamin D deficiency; - lamotrigine 100 mg, take one tablet by mouth every morning for mood; - lorazepam 1 mg, take one tablet by mouth twice daily for anxiety; - propranolol 10 mg, take one tablet by mouth twice a day for schizophrenia; - senna 8.6 mg, take two tablets by mouth twice a day for constipation; - glycopyrrol 1 mg, take one tablet by mouth in the afternoon and every night at bedtime for excessive drooling; - atropine 1%, place one drop under left and right side of tongue at night for drooling; - haloperidol 5 mg, take one tablet every night at bed for agitation; - melatonin 3 mg, take one tablet by mouth every night at bedtime for insomnia; - trazodone 50 mg, take one tablet by mouth every night at bedtime for insomnia; - acetaminophen 325 mg, take two tablets by mouth every four hours as needed for mild pain; - haloperidol 5 mg, take one additional tablet daily as needed for agitation; - lorazepam 1 mg, take one tablet daily as needed for anxiety; - polyethylene glycol 17 grams, dissolve 17 grams in 8 ounces of liquid and drink daily as needed for	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36590	A. BUILDING: _____ B. WING _____	06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS HOUSING INC	6250 RAINBOW DRIVE NE FRIDLEY, MN 55432

(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
01820	Continued From page 27 constipation; and - senna 8.6 mg, take one tablet by mouth twice a day as needed for constipation. R1's record lacked signed provider orders for the following: - vitamin D3 25 mcg, take one capsule by mouth daily for vitamin D deficiency; - haloperidol 5 mg, take one tablet every night at bed for agitation; - atropine 1%, place one drop under left and right side of tongue at night for drooling; - acetaminophen 325 mg, take two tablets by mouth every four hours as needed for mild pain; - haloperidol 5 mg, take one additional tablet daily as needed for agitation; and - senna 8.6 mg, take one tablet by mouth twice a day as needed for constipation. On June16, 2026, at 10:53 a.m., owner/unlicensed personnel (O/ULP)-A stated she agrees they do not have a signed provider order for several of R1's medications because they thought the after-visit summary (AVS) from the hospital would be considered an order. O/ULP-A stated the AVS is not electronically signed and will either need to get electronic prescriptions from the pharmacy or will get signed orders at R1's upcoming primary care visit that is scheduled soon. On June 16, 2026, at 1:20 p.m., clinical nurse supervisor (CNS)-B stated when there are medication changes on an AVS a follow up fax should be sent to the provider to get signed orders, but a fax was not sent to get signed orders for these medication changes and must have been missed by her. The licensee's 7.20 Medication and Treatment	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36590	A. BUILDING: _____ B. WING _____	06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS HOUSING INC	6250 RAINBOW DRIVE NE FRIDLEY, MN 55432

(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
01820	Continued From page 28 Orders policy dated August 1, 2021, indicated an order for medication or treatment must be dated, signed by the prescriber and must be current and consistent with the residents nursing assessment. Upon receiving verbal orders or unsigned electronic orders, a licensed nurse will record and sign the order and forward the written order to the prescriber for a signature after receipt of the verbal or electronic order. The licensed nurse will continue to follow up with the prescriber's office until the signature is received. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure expired medications were disposed of for one of three residents (R1). 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	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36590	A. BUILDING: _____ B. WING _____	06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS HOUSING INC	6250 RAINBOW DRIVE NE FRIDLEY, MN 55432

(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
01890	Continued From page 29 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On June 16, 2026, at 11:10 a.m., the surveyor observed the locked medication cabinet with owner/unlicensed personnel (O/ULP)-A. The cabinet contained all three residents' medications. The cabinet contained two medication cards for R1's lorazepam 1mg tablets both expired on May 31, 2026. O/ULP-A confirmed the expiration date and stated she did not realize these medications were expired and will advise the nurse and have her come dispose of them. On June 16, 2026, at 1:20 p.m., clinical nurse supervisor (CNS)-B stated she thinks the medication cards were missed during the medication cart audit and completes the audit at least once a month. The licensee's 7.23 Medication Disposal policy dated August 1, 2021, indicated Expired medications managed by licensee will be disposed of according to the accepted practices of the Minnesota board of pharmacy and the labels from the containers will be destroyed. Upon disposition, the facility must document in the residence record the disposition of the expired medication including the medications name, strength, prescription number as applicable, quantity, date of disposition, and names of staff and other individuals involved in the disposition. No further information provided.	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36590	A. BUILDING: _____ B. WING _____	06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS HOUSING INC	6250 RAINBOW DRIVE NE FRIDLEY, MN 55432

(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
01890	Continued From page 30 TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

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

Food & Beverage Inspection Report

Establishment Info

Open Arms Housing Inc
6250 RAINBOW DRIVE NE
Fridley, MN 55432
Anoka County
Parcel:

Phone:
openarmshousingmn@gmail.com

License Info

License: HFID 36590

Risk:
License:
Expires on:
CFPM: YASMIN ALI MA'ALIN
CFPM #: 63767; Exp: 12/16/2028

Inspection Info

Report Number: F1029261190
Inspection Type: Full - Single
Date: 6/15/2026 Time: 11:24:21 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 3
Total Priority 2 Orders: 4
Total Priority 3 Orders: 6
Delivery:

! **New Order: 2-200 Employee Health**
2-201.11C *Priority Level: Priority 1 CFP#: 3*
MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.
COMMENT: NO EMPLOYEE ILLNESS LOG. WITH ASSISTANCE, OPERATOR NAVIGATED TO MDH SITE AND DOWNLOADED AND PRINTED AN EMPLOYEE ILLNESS LOG. EMPLOYEE ILLNESS LOGGING, REPORTING, AND EXCLUSION REQUIREMENTS REVIEWED WITH OPERATOR.
Comply By: 6/15/2026 Originally Issued On: 6/15/2026

! **New Order: 3-300B Protection from Contamination: cross-contamination, eggs**
3-302.11A(1) *Priority Level: Priority 1 CFP#: 15*
MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.
COMMENT: UNPASTEURIZED SHELL EGGS ABOVE RTE ITEMS. OPERATOR INSTRUCTED TO STORE EGGS/EGG CARTONS IN A LEAKPROOF CONTAINER WITH HIGH SIDEWALLS AND/OR ON A LEVEL LOWER THAN RTE ITEMS.
Comply By: 6/15/2026 Originally Issued On: 6/15/2026

New Order: 3-300C Protection from Contamination: equipment/utensils, consumers
3-304.14B *Priority Level: Priority 3 CFP#: 41*
MN Rule 4626.0285B Wiping cloths used for wiping counters and other equipment surfaces must be held in an approved sanitizing solution and laundered daily.
COMMENT: DAMP WIPING CLOTH NOT IN SANITIZER. QUAT ONSITE BUT NO TEST STRIPS. QUAT MIXED BY HAND IN BUCKET AND TESTED TO 200-400 PPM. OPERATOR INDICATED THEY WOULD BE SWITCHING TO FOOD CONTACT SURFACE SINGLE USE DISPOSABLE WIPES.
Comply By: 6/15/2026 Originally Issued On: 6/15/2026

New Order: 3-500C Microbial Control: date marking
3-501.17B *Priority Level: Priority 2 CFP#: 23*
MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.
COMMENT: NO DATE MARK ON OPENED SALAD MIX. OPEN DATE KNOWN AND WITHIN 7-DAY USE WINDOW (MANUFACTURER'S USE BY 6/22). OPERATOR INSTRUCTED TO DATE MARK REQUIRED ITEMS.
Comply By: 6/15/2026 Originally Issued On: 6/15/2026

! **New Order: 3-500D Microbial Control: disposition of food**
3-501.18A *Priority Level: Priority 1 CFP#: 23*
MN Rule 4626.0405A Discard all TCS food prepared in the establishment or opened commercially packaged food when the time exceeds 7 days from the preparation or opening date or if the container or package is not marked.
COMMENT: COOKED PENNE ON DAY 8. OPERATOR INSTRUCTED TO DISCARD.
Comply By: 6/15/2026 Originally Issued On: 6/15/2026

New Order: 3-600 Food Identity
3-603.11A *Priority Level: Priority 2 CFP#: 25*
MN Rule 4626.0442A Inform consumers of the increased risk of consuming raw, undercooked or unprocessed animal foods or shellfish by way of a disclosure and reminder.
COMMENT: UNDERCOOKED ANIMAL PROTEINS PROVIDED IF REQUESTED. CONSUMER ADVISORY ABSENT. OPERATOR INSTRUCTED TO PROVIDE CONSUMER ADVISORY.
https://www.health.state.mn.us/communities/environment/food/docs/fs/consadvfs.pdf
Comply By: 7/3/2026 Originally Issued On: 6/15/2026

New Order: 4-100 Equipment Construction Materials
4-101.17 *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0490 Discontinue using wood and wood wicker as a food contact surface.
COMMENT: LARGE WOOD UTENSILS. OPERATOR INSTRUCTED TO REMOVE FROM SERVICE.
Comply By: 6/15/2026 Originally Issued On: 6/15/2026

New Order: 4-200 Equipment Design and Construction
4-201.11GMN *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.
COMMENT: ITEMS BEING PREPARED AND HELD BEYOND SAME DAY SERVICE WINDOW. OPERATOR INSTRUCTED TO DISCONTINUE.
Comply By: 6/15/2026 Originally Issued On: 6/15/2026

New Order: 4-200 Equipment Design and Construction
4-204.112A *Priority Level: Priority 3 CFP#: 36*
MN Rule 4626.0620A Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.
COMMENT: INTERNAL THERMOMETER ABSENT IN WARMEST PART OF FRIDGE. OPERATOR INSTRUCTED TO PLACE THERMOMETER INTO WARMEST PART OF FRIDGE.
Comply By: 7/3/2026 Originally Issued On: 6/15/2026

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: ITEMS OCCUPYING BOTH BASINS OF 2-COMPARTMENT SINK. HANDWASHING SINK NOT DESIGNATED. PIC INSTRUCTED TO DESIGNATE HANDWASHING SINK AND ENSURE IT IS ACCESSIBLE AT ALL TIMES.
Comply By: 6/19/2026 Originally Issued On: 6/15/2026

New Order: 6-300 Physical Facility Numbers and Capacities
6-301.12 *Priority Level: Priority 2 CFP#: 10*
MN Rule 4626.1445 Provide and maintain a supply of individual disposable towels, a continuous towel system, a heated-air hand drying device, or an approved ambient air temperature hand drying device at each handwashing sink or group of adjacent handwashing sinks.
COMMENT: NO PAPER TOWELS AT KITCHEN AND TOILET ROOM HANDWASHING SINKS. PIC INSTRUCTED TO ENSURE HANDWASHING SINKS ARE STOCKED WITH PAPER TOWELS.
Comply By: 6/15/2026 Originally Issued On: 6/15/2026

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control
6-501.11 *Priority Level: Priority 3 CFP#: 55*
MN Rule 4626.1515 Maintain the physical facilities in good repair.
COMMENT: WOOD EXPOSED FROM COUNTER LAMINATE PEELING BACK. LAMINATE MISSING IN MILLWORK CABINET AND DRAWER SURFACES. OPERATOR INSTRUCTED TO REPAIR OR REPLACE.
Comply By: 7/31/2026 Originally Issued On: 6/15/2026

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: FOOD DEBRIS AND RESIDUES IN DRAWERS AND CABINETS. OPERATOR INSTRUCTED TO CLEAN AND MAINTAIN CLEAN.
Comply By: 6/15/2026 Originally Issued On: 6/15/2026

Food & Beverage General Comment

FOOD AND BEVERAGE INSPECTION OF ALF CONDUCTED AS PART OF HRD NURSING SURVEY OF FACILITY.

SURVEYOR: SARABETH REMKER, BSN, RN NURSE EVALUATOR | HEALTH REGULATION DIVISION

ESTABLISHMENT RESIDENTIAL IN NATURE WITH LAMINATE FLOORING, WOOD/COMPOSITE WOOD CABINETS AND DRAWERS, LAMINATE COUNTERTOPS, AND SMOOTH PAINTED WALLS AND CEILING. ESTABLISHMENT USES HIGH HEAT SANITIZING DISHWASHER TO SANITIZE EQUIPMENT AND UTENSILS.

ESTABLISHMENT SERVES 3 CLIENTS. OPERATOR INDICATED THAT NONE OF THE CLIENTS ARE PART OF A HIGHLY SUSCEPTIBLE POPULATION.

OPERATOR/PIC/CFPM: YASMIN ALI MA'ALIN

IDENTIFIED CORRECTION ORDERS REVIEWED WITH OPERATOR DURING INSPECTION.

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

I acknowledge receipt of the Metro District Office inspection report number F1029261190 from 6/15/2026

YASIM MA'ALIN
HOUSE MANAGER CFPM

Trevor McCliment

Trevor McCliment,
Public Health Sanitarian 3
651-201-3957
trevor.mccliment@state.mn.us

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Temperature Observations/Recordings

Establishment Info

Open Arms Housing Inc
Fridley
County/Group: Anoka County

Inspection Info

Report Number: F1029261190
Inspection Type: Full
Date: 6/15/2026
Time: 11:24:21 AM

New Record: **Product/Item/Unit:** COOKED RICE**; Temperature Process:** Cold-Holding
Location: FRIDGE at 40 Degrees F.
Comment:
Violation Issued?: No

New Record: **Product/Item/Unit:** COOKED MEAT**; Temperature Process:** Cold-Holding
Location: FRIDGE at 41 Degrees F.
Comment:
Violation Issued?: No

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Sanitizer Observations/Recordings

Establishment Info

Open Arms Housing Inc
Fridley
County/Group: Anoka County

Inspection Info

Report Number: F1029261190
Inspection Type: Full
Date: 6/15/2026
Time: 11:24:21 AM

Sanitizing Equipment: Product: Hot Water**; Sanitizing Process:** Dish Machine
Location: Greater Than 150 Degrees F.
Comment:
Violation Issued?: No

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL36590016	**Date:** 6/16/2026
Facility Name: Open Arms Housing Inc.	
Facility Address: 6250 Rainbow Drive NE Fridley, MN 55432	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]

2. Egress doors shall be readily operable from the egress side without the use of a key or special knowledge. [Minn. Stat. 144G.45 subd. 2; MSFC 1010.1.9]

Comments: The door handle going down to the basement had a lock on it but did not have a handle so that it could not be easily opened and able to access.

2. A means of egress shall be free from obstructions that would prevent its use, including the accumulation of snow and ice. Means of egress shall remain free of any material or matter where its presence would obstruct or render the means of egress hazardous. No combustible material storage is allowed in the corridors or exit stairs. [Minn. Stat. 144G.45 subd. 2; MSFC 1031.3]

Comments: *Bedroom #4 has a window well cover that blocked the egress window from opening. There were personal items in the entryway and in front of the emergency exit door going out the east side of the house.*

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

1. The physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment are in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. [Minn. Stat. 144G.45 subd.2]

Comments: A piece of the siding on the east side of the house was coming off.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

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1. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include employee actions to be taken in the event of a fire or similar emergency. [Minn. Stat. 144G.45 subd.2]

   Comments: This plan was very generic and had no specific actions for employees to take in a fire safety emergency. The plan referenced smoke compartment doors and sprinklers that the facility did not have. It also indicated that the security system was directly wired to the fire station, which it was not. Owner/unlicensed personnel (O/ULP)-X stated she understood the requirements of this plan and would work on changing it.

2. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include fire protection procedures necessary for residents. [Minn. Stat. 144G.45 subd.2]

   Comments: The FSEP did not include procedures necessary for residents. The policy indicated that staff should remove all tenants from danger and that they should be evacuated to the nearest set of smoke compartment doors, which this facility did not have.

3. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include 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. [Minn. Stat. 144G.45 subd.2]

   Comments: The FSEP failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include the identification of any residents that needed assistance, any resident-specific procedures to staff for assisting residents during evacuation, nor did it include instructions for staff to follow in case of relocation.

4. Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. [Minn. Stat. 144G.45 subd.2]

   Comments: O/ULP stated that the employees were trained on the FSEP once per year and not twice per year and upon hire as required.

5. 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. [Minn. Stat. 144G.45 subd.2]

Comments: O/ULP stated that the residents were receiving evacuation training upon admission but were not getting trained once per year after that.