DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 4, 2022

Administrator
Open Arms, LLC
14737 Innsbrook Lane
Burnsville, MN 55306

RE: Project Number(s) SL35020015

Dear Administrator:

On August 31, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on June 15, 2022. This follow-up evaluation determined your facility had corrected all of the state licensing orders issued pursuant to the June 15, 2022 evaluation.

Also, at the time of this follow-up evaluation completed on August 31, 2022, we identified the following violation(s):

0630-Compliance With Requirements For Reporting Ma-144g.42 Subd. 6 (b)
0930-Contract Information-144g.50 Subd. 2 (d-E; 1-4)
0970-Waivers Of Liability Prohibited-144.50 Subd. 5
1620-Initial Reviews, Assessments, And Monitoring-144g.70 Subd. 2 (c-E)
1640-Service Plan, Implementation And Revisions To-144g.70 Subd. 4 (a-E)
1730-Individualized Medication Management Plan-144g.71 Subd. 5
1760-Documentation Of Administration Of Medication-144g.71 Subd. 8
1820-Prescriptions-144g.71 Subd. 13
1940-Individualized Treatment Or Therapy Managemen-144g.72 Subd. 3
1970-Treatment And Therapy Orders-144g.72 Subd. 6

The details of the violation(s) noted at the time of this follow-up evaluation are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these licensing orders. It is not necessary to develop a plan of correction.

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

IMPOSITION OF FINES:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in §144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in §144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in §144G.20.

CORRECTION ORDER RECONSIDERATION PROCESS

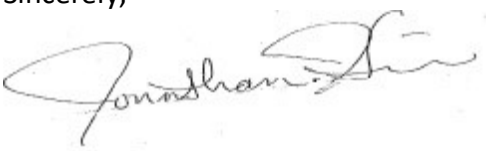
In accordance with Minn. Stat. § 144G.32, Subd. 2, you have one opportunity to challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. This written request must be received by the Department of Health within 15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

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

We urge you to review these orders carefully. If you have questions, please contact Jonathan Hill at 651-201-3993.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Sincerely,



Jonathan Hill, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-3993 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35020	A. BUILDING: _____ B. WING _____	R 08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS LLC	14737 INNSBROOK LANE BURNSVILLE, MN 55306

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments Initial comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: Project SL35020015-1 On August 30, through August 31, 2022, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on June 15, 2022. At the time of the survey, there were five (5) residents receiving services under the Assisted Living license. As a result of the revisit, the following orders were issued.	{0 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care/Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144A.474 subd. 11 (b) (1) (2) -or- 144G.31 subd. 1, 2 and 3	

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0 630	Continued From page 1	0 630		
0 630 SS=F	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 interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) contained statements of the specific measures to be taken by staff to minimize the risk of abuse for two of two residents (R1, 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 began receiving services under the assisted living license August 1, 2021. R1 diagnoses included traumatic brain injury and fetal alcohol syndrome.	0 630		

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0 630	Continued From page 2 R1's Vulnerability Assessment and Individual Abuse Prevention Plan (IAPP) dated December 8, 2019, indicated R1 had vulnerabilities related to orientation to place and time, speech/language, cognitive impariment, safe ambulation, falls/bruising, chronic conditions such as "pain/illness/disability", management of finances, wandering/elopement, susceptible to abuse, risk of abusing others, and risk of self-abuse. The form included pre-filled options with intervention choices checked. R2 was admitted September 1, 2021, and had diagnoses including anxiety, depression, bipolar disorder, and chemical dependence. R2's Vulnerability Assessment and Individual Abuse Prevention Plan (IAPP) dated September 1, 2021, indicated R2 had vulnerabilities related to a history of alcohol and "other chemical" abuse, and chronic conditions such as "pain/illness/disability." The form included pre-filled options for interventions and none were checked. R1 and R2's IAPPs lacked individualized interventions. The same pre-filled options were present on the IAPP for both residents R1 and R2. No check marks were present indicating applicable interventions for R2. On August 30, 2022, at 1:10 p.m. licensed assisted living director (LALD)-D verified no interventions were identified on IAPPs, interventions should have been individualized for each resident. No further information provided.	0 630		

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0 630	Continued From page 3 TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: No further action needed	{0 780}		
{0 790} SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire	{0 790}		

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{0 790}	Continued From page 4 extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: No further action needed	{0 790}		
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: No further action needed	{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;	{0 810}		

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{0 810}	Continued From page 5 (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No further action needed	{0 810}		
0 930 SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve	0 930		

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0 930	Continued From page 6 complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for two of two residents (R1, R2). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 received services including: assistance with medication management, behavioral management, mental health, hygiene/grooming, dressing, bathing, toileting, laundry,	0 930		

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0 930	Continued From page 7 housekeeping, meals, and socialization. R2 received services including: assistance with medication management, behavioral management, mental health, hygiene/grooming, laundry, housekeeping, meals, and socialization. R1 and R2's assisted living contracts signed May 13, 2022, and February 9, 2022, respectively, lacked: -clear and conspicuous notice of: 1. the right under section 144G.54 to appeal the termination of an assisted living contract; On August 30, 2022, at 5:05 p.m. LALD-D verified the contract lacked the residents' right to appeal termination of the contract. LALD-D stated all residents received the same contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 930		
0 970 SS=F	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the	0 970		

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0 970	Continued From page 8	0 970		

licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident. This had the potential to affect all five (5) residents living at the facility.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

R1 received services including: assistance with mental health support, behavioral management, medication management, dressing, laundry, housekeeping, incontinence, food preparation, socialization, and reassessments.

The licensee's Assisted Living Contract, signed by R1's guardian on May 13, 2022, included the following language indicating waivers of liability:
Page 4:
-"Security/Valuables/Keys: All resident rooms have security locks. If you choose not to lock your valuables, you assume liability for them.";

Page 7:
-"Insurance: Each resident should maintain his or her own health, personal property, liability, and other applicable insurance policies. [Licensee] does not provide insurance for your or your property.";

Page 12:
-"Insurance Liability and Release: The resident

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0 970	Continued From page 9 shall maintain at all times his or her own health, personal property, liability, automobile (if applicable), and other insurance coverages and shall provide evidence of same by copies of binders or policies to [Licensee] upon request. The resident acknowledges that [Licensee] is not an insurer of the resident's person or property. The resident agrees that [Licensee] will not be liable to the resident for any personal injury or property damage (including, without limitation, damage to, or loss or theft of, automobiles or personal property of resident) suffered by the resident or the resident's agents, guests, or invitees, unless and to the extent that the injury or damage is caused by the negligence of [Licensee] or its employees or agents. The resident hereby releases [Licensee] from liability for any personal injury or property damage suffered by the resident or the resident's agents, guests, or invitees, unless caused by the negligence of [Licensee] or its employees or agents."; Page 14: -"Indemnification: [Licensee] shall not be liable for any damage or injury to the resident, or any other person, or to any property, occurring on the premises, or any part thereof, or in common areas thereof, and the resident agrees to hold [Licensee] harmless from any claims or damages unless caused solely by negligence of [Licensee]. It is recommended that renter's insurance be purchased at the resident's expense. Nothing contained herein is intended to create a waiver of facility liability for the health and safety or personal property of a resident."; and -"Liability: The resident agrees to be liable and responsible for all obligations herein referenced, monetary and otherwise, of the resident and	0 970		

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0 970	Continued From page 10 where this Contract has been executed by a party designated below. Or where a separate Responsible Party Agreement has been executed by a third party, said third party and the resident shall be jointly and severally liable and responsible for all obligations, monetary and otherwise, of the resident herein referenced." On August 30, 2022, at 12:42 p.m. licensed assisted living director (LALD)-D verfied the waiver of liability language in R1's contract. LALD-D stated the contact was the same for all residents at the facility No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01620 SS=F	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 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.	01620		

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01620	Continued From page 11 (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 resident monitoring and reassessment, not to exceed 90 calendar days from the last date of the assessment for two of two residents (R1, 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 began receiving services under the Assisted Living license August 1, 2021. R1's undated service plan indicated R1 received services including: assistance with medication management, behavioral management, mental health, hygiene/grooming, dressing, bathing, toileting, laundry, housekeeping, meals, and socialization. R1's record included a uniform assessment tool dated as completed on September 3, 2021. The	01620		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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uniform assessment tool indicated a face-to-face reassessment was completed December 3, 2021 (91 days after the previous assessment), March 2, 2022, and May 30, 2022. The documentation lacked specific information regarding what was included in the reassessments.

R2 was admitted September 1, 2021.

R2's service plan, dated September 1, 2021, indicated R2 received services including: assistance with medication management, behavioral management, mental health, hygiene/grooming, laundry, housekeeping, meals, and socialization.

R2's record included a uniform assessment tool completed September 1, 2021. The uniform assessment tool indicated a face-to-face reassessment was completed December 1, 2021 (91 days after the previous assessment), March 1, 2022, May 26, 2022, May 30, 2022, and August 23, 2022. The documentation lacked specific information regarding what was included in the reassessments.

On August 30, 2022, at 4:16 p.m. house manager (HM)-B stated they were unable to provide documentation of the details of the reassessments completed by the RN.
-at 4:44 p.m. HM-B stated they were trying to transition to an electronic record keeping program for documentation of nursing assessments. HM-B verified the documentation of reassessments lacked the details present in the initial assessment.

The licensee's Assessment and Reassessment policy dated, January 10, 2022, indicated, "An individualized initial evaluation of all new

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01620	Continued From page 13 residents will be completed by a Registered Nurse in order to develop a personalized service plan. The assessment shall be revised regularly and as appropriate." The policy further indicated "Ongoing resident reassessments must be conducted by an RN and cannot exceed 90 days from the last date of assessment." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=D	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. (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.	01640		

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01640	Continued From page 14 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a signed service plan 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 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 received services including: assistance with mental health management, behavioral management, medication management, dressing, laundry, housekeeping, continence assistance, food preparation, socialization, and reassessments. R1's record included an undated service plan. The service plan lacked a signature by the resident, resident representative; R1's record lacked documentation explaining why a signature was not obtained. On August 30, 2022, at 4:38 p.m. house manager (HM)-B acknowledged R1's record lacked a signed service plan and stated it needed to be signed by her guardian. The licensee's Service Plan policy revised January 10, 2022, indicated, "The initial service plan and any revisions are signed by a representative from [licensee] and the resident or	01640		

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01640	Continued From page 15 resident's representative, indicating agreement with the services to be provided." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
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	01730		

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01730	Continued From page 16 (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: Based on interview and record review, the licensee failed to develop and maintain a current individualized medication management plan to include all required content for two of two residents (R1, 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) 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 received services including mental health management. R1's medication management plan dated December 8, 2019 (dated prior to start of Assisted Living License services August 1, 2021),	01730		

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01730	Continued From page 17 lacked the following: - statement describing the medication management services that would be provided - specific written instructions for R1's medication administration; - procedure for notifying the registered nurse (RN)-A when there was a problem with medication services. R2 in 2021, and received services including medication management. R2's record lacked a required medication management plan. On August 30, 2022, at 1:25 p.m. house manager (HM)-B stated there was not a medication management plan for R2. HM-B further stated the medication management plan would typically be completed by the RN. On August 30, 2022, at 4:35 p.m. licensed assisted living director (LALD)-D and HM-B acknowledged a medication management plan had not been developed for R2. HM-B and LALD-D further acknowledged R1's medication management plan was lacking required content. The Licensee's Service Plan for Medication Management policy and procedure, dated January 10, 2022, indicated, "[Licensee] will prepare and document a Medication Management Plan as part of the Service Plan for each resident receiving medication management services." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		

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01760 SS=E	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted 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 interview and record review, the licensee failed to ensure orders were transposed from the written order to the medication administration record (MAR) accurately for two of two residents (R1, 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 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	01760		

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01760	Continued From page 19	01760		

R1 began receiving assisted living services August 1, 2021, including medication management.

R1's record included an after visit summary (AVS) dated July 18, 2022. The AVS was signed by the physician and listed medication orders including:
- citalopram 20 mg tablet, take one tablet by mouth daily at 8:00 a.m.; and
- quetiapine 25 mg tablet, take one tablet by mouth twice daily.

R1's August 2022, MAR indicated the following medications were administered by the licensee:
- citalopram 20 mg tablet, take one and a half (1.5) tablets by mouth daily at 8:00 a.m.; and
- quetiapine 25 mg tablet, take one tablet by mouth three times daily.

On August 30, 2022, at 3:21 p.m. licensed assisted living director (LALD)-D and house manager (HM)-B both verified R1's medications were incorrectly transposed from the signed orders on the AVS, to the MAR.

R2
R2's record lacked signed prescriber orders. Further, R2's MAR indicated medications had not been updated to reflect orders indicated on R2's clinic AVS.

R2's record included an unsigned medication list including the following orders dated July 28, 2021:
- DULOXETINE HCL 30 MG CAPSULE, DELAYED RELEASE - Take 30 mg with 60 mg for total of 90 mg PO [by mouth] once daily Oral;
- DULOXETINE HCL 60 MG CAPSULE, DELAYED RELEASE - Take 60 mg with 30 mg for total of 90 mg PO once daily Oral.

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01760	Continued From page 20 R2's record included an unsigned medication list from a clinic visit, dated July 18, 2022, that included the following updated order: - duloxetine 60 mg capsule, take one capsule by mouth two times daily; - trazodone 100 mg tablet, take one to three (1-3) tablets by mouth nightly. R2's MAR for August 2022, indicated the following: - duloxetine 30 mg capsule, take one capsule by mouth daily, administered August 1-30, 2022; - duloxetine 60 mg capsule, take one capsule by mouth daily, administered August 1-30, 2022; - trazodone 150 mg tablet, take one tablet by mouth every night at bedtime, administered August 1-29, 2022. On August 30, 2022, at 3:40 p.m. LALD-D and HM-B both verified R2's medications list on the AVS, unsigned from July 18, 2022, differed from what was on the MAR. LALD-B stated the clinic was supposed to fax an updated medication orders list to them, but never did. They verified the AVS was unsigned and did not have signed orders. The licensee's Medication Orders policy dated January 10, 2022, indicated, "[Licensee] will maintain a current written or electronically recorded prescription for all prescribed medications managed for residents." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		

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01820	Continued From page 21	01820		
01820 SS=E	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 interview and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained and accurate for two of two residents (R1, 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 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 began receiving assisted living servcies August 1, 2021, including medication management. R1's signed prescriber orders did not match R1's medication administration record (MAR). R1's MAR included medications which were being administered without an order. R1's record included a medication list, signed by the physician July 18, 2022, including the	01820		

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01820	Continued From page 22 following: - citalopram 20 milligram (mg) tablet, take one tablet by mouth daily at 8:00 a.m.; - dexamethasone sodium phosphate 4 mg/milliliter (mL), apply one mL topically, see administration instructions for physical therapy; - ketoconazole 2%, apply 5-10 mL to wet scalp, lather, leave on 3-5 minutes, rinse; - olanzapine 15 mg capsule, take one tablet by mouth two times daily; - prenatal vit-fe-fumarate-fa prenatal multivitamin with iron 27-0.8 mg tablet, take one tablet by mouth daily; - quetiapine 25 mg tablet, take one tablet by mouth twice daily; and - terbinafine hcl 1% cream, apply topically two times daily. R1's MAR for August 2022 indicated the following medications administered without orders: -bupropion 100 mg sustained release (SR) tablet, take one tablet by mouth every morning (administered daily August 19-30); - deep sea 0.65% spray, inhale one spray in each nostril twice a day (administered daily August 17-30); and - lybalvi 15-10 mg tablet, take one tablet at bedtime daily (administered daily August 17-29); R1's MAR for August 2022 indicated the following medications administered inconsistently with signed prescriber orders: - citalopram 20 mg tablet, take one and a half (1.5) tablets by mouth daily at 8:00 a.m.; and - quetiapine 25 mg tablet, take one tablet by mouth three times per day. R1's MAR for August 2022 indicated the following medications were not administered as ordered: - dexamethasone sodium phosphate 4 mg/mL,	01820		

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apply one mL topically, see administration instructions for physical therapy;
- ketoconazole 2%, apply 5-10 mL to wet scalp, lather, leave on 3-5 minutes, rinse;
- olanzapine 15 mg capsule, take one tablet by mouth two times daily;
- prenatal vit-fe-fumarate-fa prenatal multivitamin with iron 27-0.8mg tablet, take one tablet by mouth daily; and
- terbinafine hcl 1% cream, apply topically two times daily.

On August 30, 2022, at 3:21 p.m. licensed assisted living director (LALD)-D and house manager (HM)-B both acknowledged R1's medications were not the same on the MAR as they were on the signed orders list. LALD-B stated the clinic said they would provide updated orders to the licensee, but never did.

R2
R2 was admitted on September 1, 2021, and received services including medication management.

R2's August medication administration record (MAR) indicated the following medications were administered August 1-30, 2022:
- atomoxetine hcl 100mg capsule, take one capsule by mouth in the morning;
- buspirone 7.5 mg tablet, take one tablet by mouth three times per day;
- duloxetine 30 mg capsule, take one capsule by mouth daily;
- duloxetine 60 mg capsule, take one capsule by mouth daily;
- multivitamin prenatal, take one tablet by mouth daily:
- naltrexone 50 mg tablet, take one tablet by mouth daily;

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01820	Continued From page 24 - risperidone 4 mg tablet, take one tablet by mouth daily; - senexon 8.6-50 mg tablet, take one tablet by mouth every other night at bedtime; - trazodone 150 mg, take one tablet by mouth every night at bedtime; and - tri-estaryll tablet, take one tablet by mouth daily. R2's records included medication list dated July 18, 2022, but lacked signed orders for the above listed medications. On August 30, 2022, at 3:40 p.m., LALD-D and HM-B both verified R2's medications list on the AVS, unsigned from July 18, 2022, differed from what was on the MAR. LALD-B stated the clinic was supposed to fax an updated medication orders list to them, but never did. They verfied the AVS was unsigned and did not have signed orders. The licensee's Medication Orders policy dated January 10, 2022, indicated, "[Licensee] will maintain a current written or electronically recorded prescription for all prescribed medications managed for residents." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
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	01940		

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01940	Continued From page 25 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 prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The licensee further failed to develop and maintain a current individualized treatment and therapy management record to include all required content for one of one resident (R1). This practice resulted in a level two violation (a	01940		

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violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).

The findings include:

R1 began receiving services under the Assisted Living license August 1, 2021. During the original evaluation on June 13, 2022, at 12:50 p.m. unlicensed personnel (ULP)-C was observed to assist R1 to remove and replace an orthotic on R1's left lower extremity.

On August 30, 2022, at 11:05 a.m. R1 was observed seated in the living room wearing an orthotic brace (an external device worn for support) on the left lower extremity including R1's ankle and calf.

R1's treatment administration record (TAR) for August 2022, indicated R1's skin was monitored daily when applying and removing the orthotic.

R1's undated service plan indicated R1 received services including assistance with medication management, behavioral management, mental health, hygiene/grooming, dressing, bathing, toileting, laundry, housekeeping, meals, and socialization. R1's service plan lacked information regarding assistance with R1's left lower extremity orthotic.

R1's record lacked a current, individualized treatment or therapy management plan for assistance with R1's orthotic to include:
-documentation of specific resident instructions

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35020	A. BUILDING: _____ B. WING _____	R 08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS LLC	14737 INNSBROOK LANE BURNSVILLE, MN 55306

(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
01940	Continued From page 27 relating to the treatments or therapy administration; -identification of treatment or therapy tasks that will be delegated to unlicensed personnel; 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. On August 30, 2022, at 2:11 p.m., house manager (HM)-B verified staff performed skin checks daily, related R1's orthotic use. On August 30, 2022, at 4:35 p.m., licensed assisted living director (LALD)-D acknowledged they needed to develop a treatment and therapy management plan for R1. LALD-D further acknowledged they would include treatment information in the residents' service plan. The licensee's treatment and therapy management policy dated January 10, 2022, indicated, "The RN or licensed professional will prepare an individualized treatment or therapy management plan for each resident receiving ordered or prescribed treatments or therapy services, which addresses: a. Type of service to be provided b. Procedures for documenting treatments or therapies c. Procedures for monitoring treatments or therapies to prevent possible complications or adverse reactions d. Identification of treatment or therapy tasks delegated to unlicensed personnel e. Procedures for notifying the RN or licensed health professional when a problem arises related to the treatment or therapy service."	01940		

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01940	Continued From page 28 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01940		
01970 SS=D	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 obtain prescriber orders for all treatments and therapies, including the frequency, duration and other information needed to administer the treatment or therapy 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, 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:	01970		

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01970	Continued From page 29 R1 was admitted December 6, 2019, and began receiving services under the Assisted Living license August 1, 2021. During the original evaluation on June 13, 2022, at 12:50 p.m. unlicensed personnel (ULP)-C was observed to assist R1 to remove and replace an orthotic on R1's left lower extremity. On August 30, 2022, at 11:05 a.m. R1 was observed seated in the living room wearing an orthotic brace (an external device worn for support) on the left lower extremity including R1's ankle and calf. R1's treatment administration record (TAR) for August 2022, indicated R1's skin was monitored daily when applying and removing the orthotic. R1's record lacked a signed prescriber order directing the use of the orthotic. On August 30, 2022, at 2:10 p.m., licensed assisted living director (LALD)-D stated she was sure she had an order for R1's orthotic. -at 2:11 p.m., house manager (HM)-B stated the order for R1's orthotic was supposed to be faxed to the licensee after a medical appointment but never was. HM-B verified staff performed skin checks regularly and documented on the treatment administration record (TAR). The licensee's treatment and therapy management policy dated January 10, 2022, indicated, "The RN or licensed health professional will obtain orders or prescriptions for all treatments and therapies. The order will include the following elements: a. Resident Name b. Description of the treatment or therapy to be provided	01970		

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01970	Continued From page 30 c. Frequency d. Other pertinent information." No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	01970		

Electronically Delivered

July 21, 2022

Administrator
Open Arms, LLC
14737 Innsbrook Lane
Burnsville, MN 55306

RE: Project Number(s) SL35020015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on June 15, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

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

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

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place

Free from Maltreatment reconsideration requests should be addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place

St. Paul, MN 55164-0970 St. Paul, MN 55164-0970

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Jonathan Hill, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-3993 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35020	A. BUILDING: _____ B. WING _____	06/15/2022

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0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL35020015 On, June 13 through June 15, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were four (4) residents, all of whom received services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.	
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was registered with the Minnesota Board of Executives for Long Term Services and Supports (BELTSS) as the Director of Record for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: LALD-D started employment in January 2018, under the licensee's Comprehensive home care license and began providing Assisted Living services on August 1, 2021. On June 13, 2022, at 11:04 a.m., the Minnesota BELTSS website was reviewed which indicated LALD-D was not registered as the Director of Record for the licensed facility. During an interview on June 13, 2022, at 11:04	0 110		

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0 110	Continued From page 2 a.m., house manager (HM)-B confirmed LALD-D was not listed as the Director of Record on the BELTSS website. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman	0 250		

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0 250	Continued From page 3 access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure representatives of the department of health had access to employee files to review for compliance. This had the potential to affect all four (4) current residents of 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	0 250		

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0 250	Continued From page 4 of the residents). The findings include: During an interview on June 13, 2022, at 8:30 a.m., licensed assisted living director (LALD)-D stated they were out of town and unavailable for the survey. LALD-D further stated the employee records and most of the client records were inaccessible because she inadvertently took the office and file cabinet keys. LALD-D indicated registered nurse (RN)-A would be available, but did not have access to the records. On June 13, 2022, at 12:27 p.m., house manager (HM)-B stated they did not have access to resident records including, but not limited to individualized abuse prevention plan (IAPP), assessments, service plans, and all signed documents, because they were located in the locked office. During the course of the survey from June 13, 2022, through June 15, 2022, the surveyor confirmed resident records and employee records were not available. Employee and resident rosters, resident face sheets and medication administration records were provided as well as emergency procedures and requested policies. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 250		
0 490 SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (ii) weekly housekeeping;	0 490		

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0 490	Continued From page 5 (iii) weekly laundry service; (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide a daily program of social and recreational activities that are based upon individual and group interests or physical, mental, and psychosocial needs. This had the potential to affect all four (4) residents of the licensees 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	0 490		

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0 490	Continued From page 6 or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on June 13, 2022, at 10:45 a.m., registered nurse (RN)-A stated the licensee had a calendar for daily events including upcoming appointments, but not daily social or recreational activities. House manager (HM)-B verified they did not maintain a daily activity program or calendar. During a facility tour on June 13, 2022, at 11:50 a.m., the surveyor did not observe an activity schedule posted in the common areas of the facility. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) Days	0 490		
0 640 SS=C	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language.	0 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 640	Continued From page 7 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) in the assisted living facility. This had the potential to affect all four (4) residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On June 13, 2022, at 1:45 p.m., the surveyor observed the common area of the facility lacked a posting of the MAARC phone number. House manager (HM)-B verified the 911 number was posted, but there was no posting of the MAARC phone number. The licensee's grievance policy dated January 10, 2022, indicated the MAARC contact information would be "conspicuously posted in the residence" along with the grievance procedure. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS LLC	14737 INNSBROOK LANE BURNSVILLE, MN 55306

(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
0 780	Continued From page 8	0 780		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide a smoke alarm for resident room #3A and the interconnection of smoke alarms throughout the home as required. This has 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	0 780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35020	A. BUILDING: _____ B. WING _____	06/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS LLC	14737 INNSBROOK LANE BURNSVILLE, MN 55306

(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
0 780	Continued From page 9 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On June 15, 2022, at approximately 10:15 a.m. to 11:30 a.m., survey staff toured the home with House Manager (HM)-B. During the tour, survey staff observed the following findings: MISSING SMOKE ALARM Resident room #3A was missing a smoke alarm. Survey staff observed an empty smoke alarm housing on the wall located at approximately two feet below the ceiling. HM-B verified the finding as she stated that the room was currently not occupied. Survey staff explained to HM-B that the smoke alarm is required in the bedroom and to review the maximum location below the ceiling for compliance with code. INTERCONNECTION OF SMOKE ALARMS The smoke alarms failed to sound all smoke alarms as required for interconnection of all smoke alarms in the home. The finding was evident as the smoke alarms in resident rooms # 1A, #2A, 4B, 5B, and the hallways of the lower level and upper level outside vicinity of the resident rooms were tested and sounded local. Survey staff also explained to HM-B that when one smoke alarm in the home is activated, all smoke alarms must sound throughout for notification. HM-B verified the finding. On June 15, 2022, at approximately 12:00 p.m., during the exit interview, HM-B acknowledged the findings.	0 780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35020	A. BUILDING: _____ B. WING _____	06/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS LLC	14737 INNSBROOK LANE BURNSVILLE, MN 55306

(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
0 780	Continued From page 10 No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain portable fire extinguishers in accordance with the State Fire Code as required by MN Statute 144G.45 Subd(a)(2). This had the potential to directly affect all residents and staff. 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	0 790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35020	A. BUILDING: _____ B. WING _____	06/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS LLC	14737 INNSBROOK LANE BURNSVILLE, MN 55306

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0 790	Continued From page 11 portion or all of the residents). The findings include: On June 15, 2022, at approximately 10:15 a.m. to 11:30 a.m., survey staff toured the home with House Manager (HM)-B. During the tour, survey staff observed the following: MAIN LEVEL FLOOR Survey staff observed a portable fire extinguisher mounted about seven feet above the finished floor in the kitchen area. However, survey staff attempted to reach the unit to locate a maintenance tag, the extinguisher along with screws fell on the kitchen counter. Survey staff explained to HM-B that the portable fire extinguisher must be mounted securely and should be installed at wood stud locations or per manufacturer's recommendation for the correct installation. In addition, the portable fire extinguisher lacked a tag and records to show the required annual service and monthly inspections. LOWER-LEVEL FLOOR Survey staff observed the loose screws behind the supporting bracket of the mounted portable fire extinguisher on the wall for the lower-level floor. In addition, the extinguisher had no tag or records to show the required annual service and monthly inspections. Survey staff explained to HM-B that the portable extinguishers need to be mounted securely by locating for wood stud locations or per manufacturer's recommendation for proper and safe installation. In addition, fire extinguishers must be professionally serviced by a qualified vendor. Survey staff also explained to the HM-B that they will need to perform monthly quick inspections and keep all records. The findings	0 790		

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	35020	A. BUILDING: _____ B. WING _____	06/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS LLC	14737 INNSBROOK LANE BURNSVILLE, MN 55306

(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
0 790	Continued From page 12 were verified by the HM-B and she asked for more information about the vendors that would provide the annual service of portable fire extinguishers. On June 15, 2022, at approximately 12:00 p.m., during the exit interview, HM-B acknowledged the findings. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35020	A. BUILDING: _____ B. WING _____	06/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS LLC	14737 INNSBROOK LANE BURNSVILLE, MN 55306

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 800	Continued From page 13 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On June 15, 2022, approximately from 10:15 a.m. to 11:30 a.m., survey staff toured the home with House Manager (HM)-B. During the tour, survey staff observed the following: COMMON USE AREAS -No lighting was provided inside the bathroom on the main floor level. This was evident when survey staff turned on the light switch and no lighting was present. Survey staff asked if there was something wrong with the light switch as there was no light. HM-B explained that it was not the light switch but the bulbs that needed to be replaced. -The stairway carpet to the lower level was soiled and dirty. -The carpet in the office and living area on the main floor were soiled and dirty. -The door to the garage from the laundry room was missing a doorknob. -The lower-level patio door was marked as a secondary exit on the floor plan but was not operable for proper exiting. HM-B had difficulty opening the door and asked for other staff to assist. -The area under the deck showed a drain discharge pipe from a shower in the lower level bathroom. Ultimate point of disposal of the shower must be reviewed with the local administrator for approved discharge. HM-B verified the finding. RESIDENT ROOM #1A	0 800		

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	35020	A. BUILDING: _____ B. WING _____	06/15/2022

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0 800	Continued From page 14 -The window treatment panel fell off when the HM-B attempted to open the egress window. Survey staff also observed other window treatment panels sitting on the floor in the corner of the room. HM-B stated that they will repair the window treatment. -The toilet paper holder and towel bar in the bathroom of room #1A were missing from the brackets. HM-B explained that the resident grabbed the holder and the bar to assist while in the bathroom and broke them off. Survey staff explained that accessible grab bars need to considered for installation to accommodate for resident use and well-being. -The egress window was not maintained and easily operable for use. Survey staff explained all egress window must be easily operable at all times for safe exiting. -The air return grill in the room was layered with dust. RESIDENT ROOM #2A -The room lacked lighting. Survey staff observed two of the three light bulbs in room #2A were burned out. - The air return grill in room was layered with dust. RESIDENT ROOM #3A The carpet in Room #3A, near the table, was soiled and dirty. -The air return grill in room was layered with dust. RESIDENT ROOM #4B The egress window was difficult to open and close and not easily operable. Survey staff explained all egress window must be maintained for easy operation for safe egress.	0 800		

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	35020	A. BUILDING: _____ B. WING _____	06/15/2022

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0 800	Continued From page 15 RESIDENT ROOM #5B -The egress window was difficult to open and close and not easily operable. Survey staff explained again all egress window must be maintained for easy operation for safe egress. -The carpet was heavily soiled and stained in various areas of the room especially near the bed. -The window treatment needed to be repaired and replaced. On June 15, 2022, at approximately 12:00 p.m., during the exit interview, HM-B acknowledged the findings. No further information was provided. 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) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation	0 810		

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0 810	Continued From page 16 plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide all required content on the fire safety and evacuation plan, the required training on fire safety and evacuation plan, and the minimum number of evacuation drills. This has the potential to directly affect the safety of all residents receiving care, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On June 15, 2022, at approximately 11:30 a.m.,	0 810		

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0 810	Continued From page 17 survey staff received and reviewed the facility's fire safety and evacuation documentation, the evacuation drill, and the training documentation from the housing manager (HM)-B. FIRE SAFETY AND EVACUATION PLAN -The floor plan incorrectly indicated the exit route to the garage door as one mean of egress. -The plan documentation lacked fire protection procedures for residents. EVACUATION DRILLS Review of the evacuation drill records indicated the minimum number of drills were not performed as required. Record review showed drills performed on January 3, 2022, at 9:37 a.m., and May 2, 2022, at 4:55 p.m., with no documented employee participant(s) for the drill dated May 2, 2022. No other records were provided for review. TRAINING of FIRE SAFETY and EVACUATION The review of the training documentation showed the correct training policy but lacked records to show the required training provided for compliance with the minimum upon hire and twice a year on the fire safety and evacuation plan. On June 15, 2022, at approximately 12:00 p.m., HM-B acknowledged the above findings at the exit interview. Survey staff advised HM-B to document all employee drills and to cover all shifts performed by employees. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 960	Continued From page 18	0 960		
0 960 SS=C	144.50 Subd. 4 Filing The contract and related documents must be maintained by the facility in files from the date of execution until five years after the contract is terminated or expires. The contracts and all associated documents must be available for on-site inspection by the commissioner at any time. The documents shall be available for viewing or copies shall be made available to the resident and the legal or designated representative at any time. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to make assisted living contracts available for on-site inspection by the surveyor. This had the potential to affect all four (4) residents of the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee started providing comprehensive services June 3, 2019, and converted to Assisted Living license on August 1, 2021. During an interview on June 13, 2022, at 8:30 a.m., licensed assisted living director (LALD)-D stated she was out of town and unavailable for the survey. LALD-D further stated the employee records and most of the client records were	0 960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 960	Continued From page 19 inaccessible because she inadvertently took the office and file cabinet keys. LALD-D indicated the registered nurse (RN)-A would be available, but did not have access to most of the records. On June 13, 2022, at 12:27 p.m., house manager (HM)-B stated they did not have access to resident paper records including the residents' signed assisted living contract. On June 15, 2022, at 7:42 a.m., a copy of the licensee's assisted living contract was requested from LALD-D via electronic mail (email), but not provided. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 960		

Minnesota Department of Health

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

Type: Full
Date: *06/22/22*
Time: 00:58:54
Report: 8087221154

Food and Beverage Establishment Inspection Report

Location:
Open Arms Llc
14737 Innsbrook Lane
Burnsville, MN55306
Dakota County, 19

Establishment Info:
ID #: 0038037
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9522425411
ID #:

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

No NEW orders were issued during this inspection.

Food and Equipment Temperatures

Process/Item: Cold Holding: SALSA
Temperature: 38 Degrees Fahrenheit - Location: STAND-UP FRIDGE
Violation Issued: No

Process/Item: Cold Holding: SOUR CREAM
Temperature: 40 Degrees Fahrenheit - Location: STAND-UP FRIDGE
Violation Issued: No

Process/Item: Cold Holding: MILK
Temperature: 39 Degrees Fahrenheit - Location: STAND-UP FRIDGE
Violation Issued: No

Process/Item: Cold Holding: DELI MEAT
Temperature: 41 Degrees Fahrenheit - Location: STAND-UP FRIDGE
Violation Issued: No

Process/Item: Ambient Air
Temperature: 38 Degrees Fahrenheit - Location: STAND-UP FRIDGE
Violation Issued: No

Process/Item: Ambient Air
Temperature: 3 Degrees Fahrenheit - Location: STAND-UP FEREZER
Violation Issued: No

Food and Beverage Establishment Inspection Report

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

THIS WAS AN ANNOUNCED AND SCHEDULED FULL INSPECTION.

INSPECTION CONDUCTED IN THE PRESENCE OF NURSE EVALUATOR II RENEE ANDERSON.

CABINETS ARE HARDWOOD, CEILING IS TEXTURED AND FLOOR IS HARDWOOD. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

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

HOT WATER TEMPERATURE AT THE KITCHEN SINK REACHED 120 DEGREES.

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

THERE IS NO CERTIFIED FOOD PROTECTION MANAGER ON STAFF.

STAND-UP FRIDGE/FREEZER IS LEAKING WATER ON TO THE FLOOR DUE TO MELTING ICE BUILD UP.

INSPECTION REPORT EMAILED TO RENEE ANDERSON.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 8087221154 of 06/22/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____
HAWA HASSAN
DSP

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