



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

January 22, 2025

Licensee

Open Heart Residence Limited

4441 Park Avenue South

Minneapolis, MN 55407

RE: Project Number(s) SL37134016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 12, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility.**

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>

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,



Renee Anderson, Supervisor

State Evaluation Team

Email: renee.anderson@state.mn.us

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

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37134	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/12/2024
NAME OF PROVIDER OR SUPPLIER OPEN HEART RESIDENCE LIMITED		STREET ADDRESS, CITY, STATE, ZIP CODE 4441 PARK AVENUE SOUTH MINNEAPOLIS, MN 55407			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 000	Initial Comments 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: SL37134016-0 On December 9, 2024, through December 12, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were four residents; four receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control	0 660			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 660	Continued From page 1 (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a baseline testing for one of two employees (unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-D was hired on July 7, 2022, and provided	0 660			

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0 660	Continued From page 2 direct care services to the residents of the facility. ULP-D's employee record included a TB history and symptom screening form completed January 11, 2022. The employee record indicated a tuberculin skin test (TST) was completed on July 22, 2022, with a negative result. ULP-D's record lacked documentation a second step TST to rule out the presence of TB. On December 10, 2024, at 10:30 a.m., owner (O)-A stated they were aware that ULP-D needed the second TST and that it had been scheduled. The licensee's 8.16 Tuberculosis Screening policy read "[licensee] will establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC)." The Minnesota Department of Health (MDH) guidelines Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, read "an employee may begin working with patients (residents) after a negative TB history and symptom screen (no symptoms of active TB disease) and a IGRA (a serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			

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0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents receiving services under the assisted living license. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 680			

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0 680	Continued From page 4 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's undated "Emergency/Disaster Plan for [Licensee]" lacked the following required content: -documentation of annual review and updates to the emergency preparedness plan; -documentation of annual review and updates to the communication plan; -policies and procedures to address the use of volunteers and other emergency staffing strategies; -documentation of participation in an annual full-scale exercise that was community based OR an annual, individual, facility-based functional exercise OR documentation if the facility experiences an actual emergency requiring activation of plan; -documentation of an additional annual exercise that may include: a second full-scale exercise that was community-based or an individual, facility based functional exercise OR mock disaster drill OR table-top exercise; and -analysis of the facility's response to and documentation of all drills, tabletop exercises and emergency events & revisions to EPP. On December 10, 2024, at 10:30 a.m., owner (O)-A stated they were unaware of all required content to the EPP and also stated the plan was reviewed annually and there should be a review page attached to the plan to document the	0 680			

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0 680	Continued From page 5 review. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment 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 comply with the current Minnesota Fire	0 780			

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0 780	Continued From page 6 Code provisions. These deficient conditions had the ability to affect all staff and residents. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 11, 2024, at 11:30 a.m., survey staff toured the facility with owner (O)-A. During the tour, the surveyor observed the following: SMOKE ALARMS 1. A smoke alarm was not installed inside occupied resident bedroom 5. 2. A smoke alarm was not installed outside occupied resident bedroom 5 in the immediate vicinity of this sleeping area. 3. When smoke alarms were tested for interconnection by the licensee, the smoke alarms installed in bedrooms. The dwelling unit smoke alarms were not interconnected as required by statute. During the facility tour interview on December 11, 2024, O-A verified the above listed observations while accompanying on the tour. DISCARDED USED SMOKING MATERIALS	0 780			

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0 780	Continued From page 7 On the same facility tour on December 11, 2024, at 11:30 a.m., with O-A, it was observed that used cigarette butts were discarded on the ground next to the building outside on the ground around the rear exit. An appropriate container was not provided for discarding the used cigarette butts. During interview on December 11, 2024, at 11:30 a.m., O-A, verified the discarded cigarette butts observed by the surveyor and stated they will get an approved receptacle. TIME PERIOD FOR CORRECTION: Two (2) days	0 780			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the 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, 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. This deficient condition had the potential to affect all staff, residents, and visitors.	0 800			

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0 800	Continued From page 8 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 11, 2024, at approximately 12:30 p.m., survey staff toured the facility with owner (O)-A., and the following was observed: EGRESS WINDOWS The egress window in bedroom 5 and bedroom 4, had a broken handle. O-A could open the window. O-A stated they were aware of the broken crank and would get it replaced. GENERAL MAINTENANCE The main level bathroom was missing a light bulb and light bulb cover. Staff explained to O-A the potential hazards the light fixture presented to the staff and residents. On December 11, 2024, at approximately 1:00 p.m., O-A stated they understood the above-listed deficiencies. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment	0 810			

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0 810	Continued From page 9 (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan (FSEP) with the required content. This had the potential to directly affect all residents, staff, and visitors.	0 810			

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0 810	Continued From page 10 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 11, 2024, at approximately 1:30 p.m., survey staff observed the fire evacuation diagrams did not identify each sleeping room. Exit plan diagrams must be correctly labeled to reduce confusion and potential obstructions to egress in a fire or similar emergency. On December 11, 2024, at approximately 1:30 p.m., survey staff observed the FSEP was not located in a central location for all staff accessibility. The FSEP was in a locked cabinet located in the main entry of the building. On December 11, 2024, O-A provided documents on the FSEP, fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The provided FSEP was from a third-party provider and had not been updated to the specific facility.	0 810			

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0 810	Continued From page 11 The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. On December 11, 2024, at approximately 2:00 p.m., O-A stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
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	01640			

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01640	Continued From page 12 about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a current written service plan was signed to reflect the current services provided 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: R1 was admitted December 8, 2023, and began receiving assisted living services. R1's record included a Service Plan signed December 8, 2023, indicating R1's received services including assistance with personal laundry, housekeeping, and medication	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37134	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/12/2024
NAME OF PROVIDER OR SUPPLIER OPEN HEART RESIDENCE LIMITED			STREET ADDRESS, CITY, STATE, ZIP CODE 4441 PARK AVENUE SOUTH MINNEAPOLIS, MN 55407		
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01640	Continued From page 13 management. The service plan lacked the frequency of medication administration assistance. On December 10, 2024, at 9:00 a.m., surveyor observed unlicensed personnel (ULP)-C administering medications to R1. R1's record included Medication Administration Record for December 2024 indicated R1 received assistance with medication administration twice a day. On December 10, 2024, at 11:30 a.m., owner (O)-A stated they were unaware the service plan had not been updated and they would check with the nurse to understand why it had not been updated. The licensee's 6.08 Service Plan policy, undated, indicated service plans and any revisions or updates would be entered into the resident's record, including changes in fees when applicable. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
01730 SS=D	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	01730			

Minnesota Department of Health

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01730	Continued From page 14 individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to 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 record for	01730			

Minnesota Department of Health

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01730	Continued From page 15 each resident to include all required content 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) 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 was admitted December 8, 2023, and began receiving assisted living services. R1's record included a Service Plan signed December 8, 2023, indicating R1's services included assistance with personal laundry and housekeeping and medication management. R1's record included Medication Administration Record for December 2024 indicated that R1 receives medication administration twice a day. R1's record lacked a current individualized medication management plan to include the following: -description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; -documentation of specific resident instructions relating to the administration of medications; -identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; -procedures for staff notifying a registered nurse or appropriate licensed health professional when	01730			

Minnesota Department of Health

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01730	Continued From page 16 a problem arises with medication management services; and -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. On December 10, 2024, at 10:30 a.m., O-A stated R1's record did not include a medication management plan and they would check with the nurse to see if it had been completed. No additional documentation was provided. The licensee's 7.03 Medication Management Individualized Plan policy, undated, indicated an individualized medication management plan would be developed and maintained for each resident receiving medication management services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
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:	01890			

Minnesota Department of Health

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01890	Continued From page 17 Based on observation and interview, the licensee failed to ensure medications included an original prescription label with legible information including the expiration or beyond-use date of a time-dated drug 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: R1's Service Plan signed December 8, 2023, indicating R1's received services including assistance with personal laundry, housekeeping, and medication management. R1's Medication Administration Record for December 2024 indicated that R1 received medication administration twice a day. On December 10, 2024, at 10:00 a.m., a review of the medication storage area had a storage box with R1's medication bottles. At the bottom of the box five unidentified lose medication were laying at the bottom on the box. On December 10, 2024, at 10:15 a.m., unlicensed personnel (ULP)-C stated they were not aware of the pills in the bottom of the box and if they had noticed the medication outside of the bottles they would notify the nurse. On December 10, 2024, at 10:20 a.m., owner	01890			

Minnesota Department of Health

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01890	Continued From page 18 (O)-A stated expired medication should be removed by a nurse when the medications were set up weekly. O-A stated that medication should be destroyed according to the licensee's policy and procedures. The licensee's undated Medications Storage policy indicated, " Medications will be stored consistent with manufacturer's recommendations " No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			

Type: Full
Date: 12/09/24
Time: 13:50:00
Report: 1013241138

Food and Beverage Establishment Inspection Report

Page 1

Location:

Open Heart Llc
4441 Park Avenue South
Minneapolis, MN55407
Hennepin County, 27

Establishment Info:

ID #: 0038882
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6129781757
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.

Surface and Equipment Sanitizers

Hot Water: = at 165 Degrees Fahrenheit
Location: Dish machine
Violation Issued: No

Chlorine: = 200 ppm at Degrees Fahrenheit
Location: Sanitizer - kitchen prep area
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Raw beef
Temperature: 12 Degrees Fahrenheit - Location: Freezer
Violation Issued: No

Process/Item: Cheese
Temperature: 41 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: No

Process/Item: Half and half
Temperature: 41 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: No

Process/Item: Eggs
Temperature: 41 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: No

Type: Full
Date: 12/09/24
Time: 13:50:00
Report: 1013241138
Open Heart Llc

Food and Beverage Establishment
Inspection Report

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

The inspection was completed with the operator then reviewed with MDH Nurse Evaluator A. Woehler.

The establishment has a residential kitchen and serves food that is prepared that day. The kitchen has wood cabinets, tile floor, tile walls, solid counter top, and a textured painted ceiling.

A two basin sink is located in the kitchen. One basin is designated for hand washing.

A residential dish machine is used to wash ware. The dish machine is run on the sanitize/high temperature cycle.

Discussed hand washing, ware washing, staff illness policy, temperature control, final cook temperatures, cleaning, serving highly susceptible populations, glove use, food storage, and food handling procedures.

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 1013241138 of 12/09/24.

Certified Food Protection ManagerRowda Farah

Certification Number: 108591 Expires: 09/27/27

Inspection report reviewed with person in charge and emailed.

Signed:Abdirizak Osman
Operator

Signed:Jerry Malloy
Sanitarian Supervisor
FPLS Metro
651-201-3998
jerry.malloy@state.mn.us