Electronically Delivered

December 16, 2024

Licensee
Open Heart Residence
4945 Drew Avenue South
Minneapolis, MN 55410

RE: Project Number(s) SL37990016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on November 15, 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,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37990	A. BUILDING: _____ B. WING _____	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN HEART RESIDENCE	4945 DREW AVENUE SOUTH MINNEAPOLIS, MN 55410

(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: SL37990016-0 On , November 12, 2024, through November 15, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were four (4) resident(s); 4 receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated November 12, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled	0 650		

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0 650	Continued From page 2 volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records included all required content for two of two employees (unlicensed personnel (ULP)-B, ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 number or all the residents).	0 650		

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0 650	Continued From page 3 The findings include: ULP-B ULP-B was hired November 11, 2022, and began providing assisted living services. ULP-B's record lacked documentation of annual performance reviews that identified areas of improvement needed and training needs. ULP-C ULP-C was hired November 10, 2022, and began providing assisted living services. ULP-C's record lacked a signed job description and annual performance reviews that identified areas of improvement needed and training needs. On November 13, 2024, at approximately 4:30 p.m., owner (O)-A reviewed the employee files with the surveyor and stated the performance reviews and job description were not in the files. O-A stated they did not know why the files were missing the required content. The licensee's 4.05 Employee Records policy dated August 1, 2021, indicated employee records would contain a signed job description and annual performance reviews identifying areas of improvement and training needs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		

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0 660	Continued From page 4	0 660		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: 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 maintaining a current Facility TB Risk Assessment and baseline screening and testing for one of two employees (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect	0 660		

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0 660	Continued From page 5 a large portion or all of the residents). The findings include: The Facility TB Risk Assessment dated December 20, 2022, indicated the facility was a low risk setting for TB transmission. The Facility TB Risk Assessment included a notation stating reviewed: March 4, 2024, and initials at the end of the document. The content of the assessment did not include current information. ULP-C was hired November 10, 2022, and began providing assisted living services. ULP-C's employee record included a TB history and symptom screening dated July 11, 2022, and a single TST administered July 13, 2022. ULP-C's tuberculin skin test (TST) was administered greater than 90 days prior to ULP-C's date of hire and ULP-C's record lacked evidence of a second TST. On November 12, 2024, at approximately 4:30 p.m., owner (O)-A stated they were unaware the Facility TB Risk Assessment had not been completed for 2023 and that two TSTs were required as part of the employee screening process. 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	0 660		

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0 660	Continued From page 6 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		
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	0 680		

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0 680	Continued From page 7 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 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	0 680		

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0 680	Continued From page 8 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 November 12, 2024, at approximately 4:30 p.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. The licensee's Emergency Preparedness Plan - Appendix Z Compliance policy dated August 1, 2024, indicated it is the intent that [licensee] have in place an effective and compliant EPP. The intent is the plan will be aligned with the Centers for Medicare and Medicaid Services State Operations Manual Appendix Z. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
01440 SS=E	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living	01440		

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01440	Continued From page 9 facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) supervised unlicensed personnel (ULP) within 30 calendar days of beginning to provide delegated tasks for two of two employees (ULP-B, ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a 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:	01440		

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01440	Continued From page 10 ULP-B ULP-B was hired November 11, 2022, and began providing assisted living services. On November 12, 2024, at approximately 1:00 p.m., ULP-B was observed administering medications to R3. ULP-B's employee record lacked documentation of direct supervision within 30 days of performing delegated tasks. ULP-C ULP-C was hired November 10, 2022, and began providing assisted living services. ULP-C's employee file lacked documentation of direct supervision within 30 days of performing delegated tasks. On November 12, 2024, at approximately 4:30 p.m., owner (O)-A stated they were unaware that 30-day supervision by a registered nurse had not been completed. The licensee's 6.17 Supervision of Staff-Delegated Services policy dated August 1, 2021, read "direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for [licensee] and firs performs the delegated tasks for residents and thereafter as needed based on performance." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		

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01470	Continued From page 11	01470		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this	01470		

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01470	Continued From page 12 subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received orientation to include all required content for two of two employees (unlicensed personnel (ULP)-B, ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect all the residents). The findings include: ULP-B ULP-B was hired on November 11, 2022, and began providing assisted living services.	01470		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN HEART RESIDENCE	4945 DREW AVENUE SOUTH MINNEAPOLIS, MN 55410

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01470	Continued From page 13 ULP-B's employee record lacked the documentation of the following required orientation topics: -overview of the Assisted Living statutes; -compliance with and the reporting of maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); -the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; and -a review of the types of assisted living services the employee will be providing and the facility's category of licensure. ULP-C ULP-C was hired on November 10, 2022, and began providing assisted living services. ULP-C's employee record lacked the documentation of the following required orientation topics: -overview of the Assisted Living statutes; -compliance with and the reporting of maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); -the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; and -a review of the types of assisted living services the employee will be providing and the facility's category of licensure. On November 12, 2024, at approximately 4:30 p.m., owner (O)-A stated they were unaware content was missing from their orientation program and would contact their representative from Educare to assist with updating their program.	01470		

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01470	Continued From page 14 The licensee's 5.01 Orientation of Staff and Supervisors & Content policy dated August 1, 2021, indicated the following content would be provided for all staff during orientation: -an overview of the appropriate assisted living statutes and rules; -compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the MAARC; -the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; and - a review of the types of assisted living services the employee will be providing and the facility's category of licensure. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing	01500		

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01500	Continued From page 15 techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication	01500		

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01500	Continued From page 16 access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure annual training was provided and included all required topics for each 12 months of employment for two of two employees (unlicensed personnel (ULP)-C, 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 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: ULP-B was hired on November 11, 2022, and began providing assisted living services. ULP-C was hired on November 10, 2022, and began providing assisted living services. ULP-B and ULP-C's employee records lacked documentation of at least eight (8) hours of annual training for each 12 months of employment. On November 12, 2024, at approximately 4:30 p.m., owner (O)-A stated they were unaware annual training had not been completed by ULP-B and ULP-C. O-A stated they thought that annual orientation had been assigned and completed by employees.	01500		

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01500	Continued From page 17 The licensee's 5.06 Annual Required Staff Training policy dated August 1, 2021, read "all staff that perform direct care services at [licensee] will complete at least eight (8) hours of annual training for each 12 months of employment." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete.	01530		

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01530	Continued From page 18 Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure direct care employees received at least two hours of training on dementia related topics for each 12 months of employment for two of two employees (unlicensed personnel (ULP)-B, ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-B was hired on November 11, 2022, and began providing assisted living services. ULP-C was hired November 10, 2022, and began providing assisted living services. ULP-B and ULP-C's employee records lacked the required annual dementia training for 2023. On November 12, 2024, at approximately 4:30 p.m., owner (O)-A stated they were unaware that annual training had not been completed and thought that it had been assigned and completed by all employees. The licensee's document titled Assisted Living	01530		

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01530	Continued From page 19 Facilities dated June 2021, indicated direct care staff were required to complete two hours of annual training on topics related to dementia care. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
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 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	01640		

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01640	Continued From page 20 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 September 17, 2023, and began receiving assisted living services. R1's record included a Service Plan signed September 27, 2023, indicating R1's services included assistance with personal laundry and housekeeping and had safety checks every two hours when resident was home. R1's record included a Medication Management Plan dated September 27, 2024, and October 4, 2024. R1's Medication Management Plan indicated medications had been ordered for R1 on October 4, 2023. On November 12, 2024, at approximately 1:00 p.m., surveyor observed unlicensed personnel (ULP)-B administering medications to R1. R1's record lacked an updated service plan indicating R1 received medication management services.	01640		

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01640	Continued From page 21 On November 12, 2024, at approximately 4:30 p.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 dated August 1, 2021, 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 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	01730		

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01730	Continued From page 22 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 each resident to include all required content for one of two residents (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 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:	01730		

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01730	Continued From page 23 R2 was admitted on September 20, 2024, and began receiving assisted living services. R2's record included an unsigned Service Plan indicating R2 received medication management services. R2's record included Medication Set Up Records dated October 2024, and November 2024, indicating R2 had receive medications between the dates of October 14, 2024, and November 11, 2024. R2's record lacked a current individualized Medication Management Plan. On November 12, 2024, during the entrance conference at approximately 10:30 a.m., owner (O)-A indicated that medication management services including medication administration was provided for all residents. On November 12, 2024, at approximately 4:30 p.m., O-A stated R2's record did not include a medication management plan and they would check with the nurse to see if it had been completed. The licensee's 7.03 Medication Management Individualized Plan policy dated August 1, 2021, 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		

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01760 SS=F	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 observation, interview, and record review, the licensee failed to document medication administration in resident records 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 number or all the residents). The findings include: R1 R1 was admitted on September 17, 2023, and began receiving assisted living services.	01760		

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01760	Continued From page 25 R1's record included a Service Plan signed September 27, 2024, indicating R1 did not have medications. R1's record included an Individualized Medication Management Plan signed on September 27, 2023, and October 4, 2023, indicating medications had been ordered for resident on October 4, 2023. R1's record included a Medication Set Up Record dated October 2024. The Medication Set Up Record indicated the licensee failed to document administration of the following medications between October 1, 2024, through October 31, 2024: -metformin 500 milligrams (mg); take two (2) tablets by mouth (PO) twice daily. The licensee failed to document the morning (AM) dose seven (7) out of 31 days and failed to document the evening (PM) dose nine (9) out of 31 days. -lisinopril 20 mg PO daily. The licensee failed to document the AM medication administration 7 out of 31 days. -atorvastatin 10 mg PO at bedtime. The licensee failed to document the medication administration 2 out of 31 days. -quetiapine 25 mg tablets; take 2 tablets PO at bedtime. The licensee failed to document the medication administration six (6) out of 31 days. R2 R2 was admitted on September 20, 2024, and began receiving assisted living services. R2's record included an undated Service Plan indicating R1's services included medication set up and reminders. R2's record included a Medication Set Up Record	01760		

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01760	Continued From page 26 dated October 2024. The Medication Set Up Record indicated the licensee failed to document administration of the following medications between October 14, 2024, through October 31, 2024: -pregabalin 75 mg capsule PO twice daily. The licensee failed to document medication administration for the AM administration three (3) out of 17 days and failed to document administration of the PM administration 7 out of 18 days. On November 12, 2024, during the entrance conference at approximately 10:30 a.m., owner (O)-A stated all residents at the facility received medication administration services. On November 12, 2024, at approximately 1:00 p.m., the surveyor observed unlicensed personnel (ULP)-B administering medications to R1. On November 12, 2023, at approximately 4:30 p.m., O-A stated they were unaware that medications had not been documented. O-A stated R-1 frequently refuses his medications. The Licensee's 7.22 Medication and Treatment Record - Documentation and Refusal policy dated August 1, 2021, indicated the following must be documented in the resident record after providing medication assistance: -date; -time; -quantity of dosage; -method of administration; and -signature and title of the authorized person who provided the assistance and/or administration of the medications/treatments/therapy.	01760		

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	37990	A. BUILDING: _____ B. WING _____	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN HEART RESIDENCE	4945 DREW AVENUE SOUTH MINNEAPOLIS, MN 55410

(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
01760	Continued From page 27 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01820 SS=F	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure there was a current, written, or electronically recorded prescription for all prescribed medications that the assisted living facility was managing 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 the residents). The findings include: R1 R1 was admitted on September 17, 2023, and began receiving assisted living services. R1's record included a Service Plan signed September 27, 2023, indicated R1's services	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37990	A. BUILDING: _____ B. WING _____	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN HEART RESIDENCE	4945 DREW AVENUE SOUTH MINNEAPOLIS, MN 55410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01820	Continued From page 28 included assistance with laundry, housekeeping and safety checks every two (2) hours when resident was home. R1's record included an Individualized Medication Management Plan, dated September 27, 2023, and October 4, 2023, indicating medications had been ordered for R1 on October 4, 2023. R1's record included an After Visit Summary (AVS) dated October 14, 2024, which included a medication list. The AVS lacked an electronic signature from an authorized prescriber. R1's record lacked a current written or electronically recorded prescription for all medications managed/administered by licensee. R2 R2 was admitted on September 20, 2024, and began receiving assisted living services. R2's record included an undated Service Plan indicating R2's received medication management services. R2's record included an AVS dated October 10, 2024, which included a medication list. The AVS lacked an electronic signature from an authorized prescriber. R2's record lacked a current written or electronically recorded prescription for all medications managed/administered by licensee. On November 12, 2024, during the entrance conference at approximately 10:30 a.m., owner (O)-A stated all residents received medication administration services.	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37990	A. BUILDING: _____ B. WING _____	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN HEART RESIDENCE	4945 DREW AVENUE SOUTH MINNEAPOLIS, MN 55410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01820	Continued From page 29 On November 12, 2024, at approximately 1:00 p.m., the surveyor observed unlicensed personnel (ULP)-B administering medications to R1. On November 12, 2024, at approximately 4:30 p.m., O-A stated the licensee considers the AVS reports received at physician appointments as their current medication orders. The licensee's 7.20 Medications and Treatment Orders policy dated August 1, 2021, indicated the registered nurse is responsible for assuring that current, authorized, prescriber orders for medications or treatments administered by the staff are kept on file in the resident records. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions. This practice resulted in a level two violation (a	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37990	A. BUILDING: _____ B. WING _____	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN HEART RESIDENCE	4945 DREW AVENUE SOUTH MINNEAPOLIS, MN 55410

(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
01880	Continued From page 30 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On November 12, 2024, during a facility tour at approximately 11:00 a.m., the surveyor observed a plastic bag containing three (3) insulin pens in the kitchen refrigerator (Lantus pens). Two of the insulin pens had been opened and were not labeled with the opening or expiration date. The insulin was stored on a shelf along with food items. The refrigerator was not locked and lacked a thermometer and documentation the refrigerator temperature was monitored. On November 12, 2024, at approximately 11:00 a.m., unlicensed personnel (ULP)-B and owner (O)-A stated they were unaware the insulin needed to be stored in a locked refrigerator and monitored for temperature. ULP-B stated they were unaware of expiration dates as R1 was independent with administering his insulin. The Lantus package insert developed by Sanofi-Aventis and revised June 2023, indicated the following instructions for storage: -store unused Lantus between 2 degrees (°) to 8° Celsius (C) (36° to 46° Fahrenheit (F)) in a refrigerator; -do not freeze. Discard Lantus if it has been frozen; -protect Lantus from direct heat or light; -Lantus that has been opened (refrigerator or room temperature) should be discarded after 28	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37990	A. BUILDING: _____ B. WING _____	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN HEART RESIDENCE	4945 DREW AVENUE SOUTH MINNEAPOLIS, MN 55410

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01880	Continued From page 31 days. The licensee's 7.11 Medication Storage policy dated August 1, 2021, read "when medications are managed and stored by [licensee], medications will be kept securely locked and stored per manufacturers directions. Only authorized staff will have access to stored medications". No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

Minnesota Department of Health
Food Pools & Lodging Services
P.O. Box 64975
St Paul, MN 55164-0975
651 201 4500

Type: Full
Date: *11/12/24*
Time: 09:22:24
Report: 8058241287

Food and Beverage Establishment Inspection Report

Location:
Open Heart Residence
4945 Drew Avenue South
Minneapolis, MN55410
Hennepin County, 27

Establishment Info:
ID #: 0041104
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/23

Operator:

Phone #:
ID #:

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

The following orders were issued during this inspection.

3-500C Microbial Control: date marking

3-501.17B ***** Priority 2 *****

MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.

DELI MEATS NOT DATE MARKED AFTER OPENING (COS)

Comply By: 11/12/24

4-600 Cleaning Equipment and Utensils

4-601.11A ***** Priority 2 *****

MN Rule 4626.0840A Equipment food-contact surfaces and utensils must be clean to sight and touch.

MICROWAVE HAS BUILD UP OF GREASE AND IS DEPOSITING GREASE ONTO CABINET FACES

Comply By: 11/22/24

Surface and Equipment Sanitizers

Hot Water: = --- at 165 Degrees Fahrenheit
Location: DISH WASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: CUCUMBER
Temperature: 38 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Type: Full
Date: *11/12/24*
Time: 09:22:24
Report: 8058241287
Open Heart Residence

Food and Beverage Establishment Inspection Report

Process/Item: MILK
Temperature: 40 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

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

HRD INSPECTOR MICHELLE WINTERS

RESIDENTIAL HOME WITH NON COMMERCIAL APPLIANCES AND FINISHES

DISH TEMP RECORDING SENT POST INSPECTION BY TEXT MESSAGE (PHOTO VERIFIED)

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 8058241287 of 11/12/24.

Certified Food Protection Manager: ROWDA FARAH

Certification Number: 108591 Expires: 09/27/27

Inspection report reviewed with person in charge and emailed.

Signed: _____
ABDI OSMAN
PIC

Signed: _____
Aaron Gertz
Sanitarian 3
MDH Metro Office
651 201 4500
health.foodlodging@state.mn.us