



STATE LICENSING COMPLIANCE REPORT

Report #: HL371342442C

Date Concluded: September 6, 2023

Name, Address, and County of Facility

Investigated:

Open Heart Residence Limited
4441 Park Avenue South
Minneapolis MN, 55407
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Kris Detsch, RN

Special Investigator

The Minnesota Department of Health conducted a complaint investigation to determine compliance with state laws and rules governing the provision of care under Minnesota Statutes, Chapter 144G. The purpose of this complaint investigation was to review if facility policies and practices comply with applicable laws and rules. No maltreatment under Minnesota Statutes, Chapter 626 was alleged.

To view a copy of the correction orders, if any, please visit:

<https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html>, or call 651-201-4201 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached state form.

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 C 08/24/2023
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	<p>Initial Comments</p> <p>ASSISTED LIVING PROVIDER CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.</p> <p>Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.</p> <p>INITIAL COMMENTS:</p> <p>#HL371342442C</p> <p>On August 24, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were three residents receiving services under the provider's Comprehensive Assisted Living license.</p> <p>The following correction orders are issued for #HL371342442C, tag identification 800, 820.</p>	0 000	<p>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 License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.</p>	
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including	0 800		

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

TITLE

(X6) DATE

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0 800	<p>Continued From page 1</p> <p>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.</p> <p>This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents and staff.</p> <p>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).</p> <p>The findings include:</p> <p>On August 24, at approximately 9:00 a.m., survey staff toured the facility with the Administrator (AD)-A. During the facility tour, survey staff observed the following:</p> <p>In the resident's room #2 on the main level, it was observed that the window glass panel was cracked, and the window operating sash cord was broken.</p> <p>In the bathroom on the main level, it was observed that the window operating sash cord</p>	0 800		

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0 800	<p>Continued From page 2</p> <p>was broken, and the wooden double-hung window would not stay open when tested. Also, it was observed that the exhaust fan was covered with black dust.</p> <p>In resident bedroom #3 on the upper level, it was observed that the window glass panel by the resident bed was cracked, and the window operating sash cord was broken. It was also observed that the glass panel in the double swing window by the resident's desk was cracked.</p> <p>In resident bedroom #4 in the basement, it was observed that the opening hardware for the window was broken and prevented the window from opening and closing. A string was hanging on the window to pull to close the window manually.</p> <p>In the resident's room #4 in the basement, it was observed that the window well was higher than 44 inches from the bottom of the well, but the window did not have the required ladder installed outside of the window to meet the egress route requirement.</p> <p>In the resident bed room #5 on basement, it was observed that the window glass panel was cracked.</p> <p>During the exterior building tour, it was observed that there was a significant gap in the foundation on the left side of the building. During the interview, AD-A stated that they had issues with rodents entering the building and have been working with licensed exterminators to remove them. In a review of the provided documentation, it was observed that the facility contracted with the licensed exterminator and received monthly service from them.</p>	0 800		

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0 800	Continued From page 3 This deficient condition was verified by AD-A accompanying the facility tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 820 SS=G	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect all residents and staff. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or	0 820		

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0 820	<p>Continued From page 4</p> <p>a limited number of staff are involved or the situation has occurred only occasionally).</p> <p>On August 24, 2023, at approximately 9:00 a.m., survey staff toured the facility with the Administrator (AD)-A. During the facility tour, survey staff observed the following items:</p> <p>In bedroom #1 on the main level, it was observed that the room had two double-hung windows. On one side of the double pane window, the glass was broken, and the sharp-edged loose glasses still remained in place to expose danger to residents. Also, it was observed that the window glazing was missing in the other double-pane window. During the interview, the resident stated that the window was broken a couple of months ago, but AD-A stated that he was unaware of the condition.</p> <p>This deficient condition was verified by AD-A accompanying the facility tour.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	0 820		