Electronically Delivered

December 6, 2024

Licensee
Open Arms Group Home LLC
3701 66th Avenue North
Brooklyn Center, MN 55429

RE: Project Number(s) SL36675015

Dear Licensee:

On November 4, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the August 13, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

JMD

Electronically Delivered

September 18, 2024

Licensee
Open Arms Group Home LLC
3701 66th Avenue North
Brooklyn Center, MN 55429

RE: Project Number(s) SL36675015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 13, 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.

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

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

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

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

0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

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

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

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

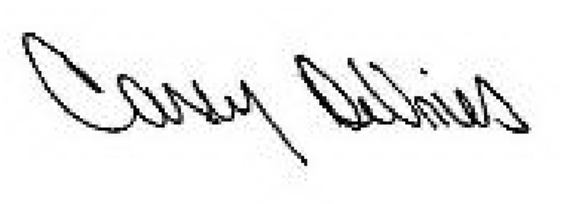
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. 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,



Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36675	A. BUILDING: _____ B. WING _____	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS GROUP HOME LLC	3701 66TH AVENUE NORTH BROOKLYN CENTER, MN 55429

(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 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: SL36675015-0 On August 12, 2024, through August 13, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were three residents, all of whom received services under the Assisted Living license. An immediate correction order was identified on August 12, 2024, issued for SL36675015-0, tag identification 0820. On August 13, 2024, the immediacy of correction order 0820 was removed, however non-compliance remained, and the scope and level remained unchanged.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care/Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144A.474 subd. 11 (b) (1) (2) -or- 144G.31 subd. 1, 2 and 3	
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements	0 460		

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0 460	Continued From page 1 (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week (24/7). 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:	0 460		

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0 460	Continued From page 2 On August 12, 2024, at 10:07 a.m., clinical nurse supervisor (CNS)-A stated they did not have a system for residents to summon staff 24/7. CNS-A stated they knew they were supposed to have one and inquired from the surveyor what kind of systems were acceptable. R2 stated they did not have any means of summoning staff if they needed assistance. On August 13, 2024, at 1:00 p.m., R2 stated they did not have a cell phone. R2 stated if they needed help, and were unable to find staff, they would call their mom to get someone to help them. R2 stated they would use ULP-B's phone to call their mom. During R2's interview, the surveyor observed two landline house phones right next to one another on the lower shelf of the living room television stand under a wall mounted television. One phone was a wireless black and silver Vtech phone, the other was a corded black and silver Vtech phone. Neither phone had their power cords plugged in and the wireless phone was not charged. On August 13, 2024, at 1:08 p.m., licensed assisted living director (LALD)-D stated the house phones were for resident use. LALD-D stated R2 used them to make phone calls to their mom. LALD-D stated they were unaware the phones were not plugged in or charged. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 460		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 3 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a staffing plan to determine staffing levels to meet the needs of all residents. Further, the licensee failed to post their daily staffing schedule in a central location accessible to staff, residents, volunteers, and the public. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 470		

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0 470	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 [Licensee] Staffing Plan form, undated, included the required staffing plan content but did not indicate when it was last reviewed or updated. On August 12, 2024, at 10:07 a.m., during the entrance conference, clinical nurse supervisor (CNS)-A stated they had a staffing plan. CNS-A stated there was supposed to be a staff schedule posted. CNS-A went to ask unlicensed personnel (ULP)-B if they had a staff schedule posted anywhere. ULP-B stated they did not have one posted, but the staff schedule was the same week to week. On August 13, 2024, at 1:55 p.m., CNS-A stated they thought the staffing plan was only required to be updated annually. The licensee's 4.06 Staffing & Scheduling policy dated September 1, 2021, indicated, "The daily work schedule must be posted, after redacting direct-care staff members' resident assignments, at the beginning of each work shift in a central location in each building of a facility or campus, accessible to staff, residents, volunteers, and the public. The facility shall not disclose any information that is protected by law from public disclosure." It further indicated: "1. The clinical nurse supervisor will develop and	0 470		

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0 470	Continued From page 5 implement a written staffing plan that provides an adequate number of qualified direct-care staff to meet the residents' needs 24-hours a day, seven-days a week. 2. The clinical nurse supervisor must ensure that staffing levels are adequate to address the following: a. Each resident's needs, as identified in the resident's service plan and assisted living contract b. Each resident's acuity level, as determined by the most recent assessment or individualized review c. The ability of staff to timely meet the residents' scheduled and reasonably foreseeable unscheduled needs given the physical layout of the facility premises d. Whether the facility has a secured dementia care unit, and e. Staff experience, training, and competency." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (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	0 480		

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0 480	Continued From page 6 review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This had the potential to affect all residents of the assisted living facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated August 13, 2024, for the specific Minnesota Food Code deficiencies. The Inspection Report was provided to the licensee on August 15, 2024. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities.	0 510		

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0 510	Continued From page 7 (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program that complied with accepted health care, medical and nursing standards for infection control. The deficient practice had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to 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: On August 12, 2024, at 9:34 a.m., the surveyor observed the house was a rambler style home which included a main floor and a basement. The main floor bathroom lacked paper towels for hand drying. On August 12, 2024, at 12:47 a.m., the surveyor observed the main floor bathroom which lacked paper towels for hand drying. On August 13, 2024, at 9:33 a.m., the surveyor observed the main floor bathroom which lacked paper towels for hand drying. On August 13, 2024, at 12:05 p.m., clinical nurse	0 510		

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0 510	Continued From page 8 supervisor (CNS)-A stated they had plenty of paper towels to keep the bathrooms stocked and was just a matter of staff putting them out. CNS-A stated they should be making sure paper towels were available for hand drying for infection control reasons. The Center for Disease Control (CDC) Clinical Safety: Hand Hygiene for Healthcare Workers webpage, last updated on February 27, 2024, indicated: "Know how to wash hands with soap and water 1. Wet hands with water. 2. Apply the manufacturer recommended amount of product to your hands. 3. Rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. 4. Rinse hands with water and use disposable towels to dry. Use a towel to turn off the faucet. 5. Avoid using hot water to prevent drying of the skin." The licensee's 8.09 Hand Washing policy dated August 1, 2021, indicated: "POLICY: Proper hand washing techniques should be used to protect the spread of infection. Hand washing shall be completed: -Before, during, and after preparing food -Before eating food -Before and after caring for someone who is sick -Before and after treating a cut or wound -After using the toilet -After changing diapers or cleaning up after someone who has used the toilet -After blowing your nose, coughing, or sneezing -After touching an animal or animal waste -After handling pet food or pet treats -After touching garbage PROCEDURE:	0 510		

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0 510	Continued From page 9 Hand washing will be performed by all employees, as necessary, between tasks and procedures, and after bathroom use, to prevent cross-contaminations. Equipment Needed: 1. Soap 2. Water 3. Paper towels Steps: 1. Stand away from the sink. Hands and sleeves must not touch the sink 2. Tum on water and adjust to a comfortably warm temperature 3. Wet hands and wrists 4. Apply soap over hands and wrists, working into a generous lather by scrubbing vigorously 5. Use friction and scrub vigorously for at least 20 seconds (long enough to sing 'Happy Birthday' twice) 6. Be sure to clean beneath the fingernails, around the knuckles and along the sides of the fingers and hands 7. Rinse hands and wrists completely under running water to wash away suds and microorganisms 8. DO NOT TURN FAUCETS OFF WITH CLEAN HANDS - see #10 below 9. Pat hands and wrists dry with a paper towel. It is unacceptable to use client towels for drying hands 10. Turn off water using a clean paper towel to prevent recontamination of the hands 11. If leaving a washroom/restroom, use paper towels to grasp door handle upon exit to prevent recontamination of clean hands." No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 510		

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0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post information directing individuals to the Office of Health Facility Complaints (OHFC) at the Minnesota Department of Health (MDH) if they had complaints about the facility or person providing services. 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:	0 550		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS GROUP HOME LLC	3701 66TH AVENUE NORTH BROOKLYN CENTER, MN 55429

(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
0 550	Continued From page 11 On August 12, 2024, at 9:40 a.m., the surveyor observed the licensee lacked the OHFC required posting information. The licensee had their grievance policy posted which lacked the OHFC required posting information. On August 13, 2024, at 11:56 a.m., clinical nurse supervisor (CNS)-A stated they did not know what OHFC was but would get it added to their posted grievance policy. The licensee's 2.10 Complaint/Grievance Posting policy dated September 1, 2021, indicated the licensee would post contact information for the Office of Ombudsman for Long Term Care and the Ombudsman for Mental Health and Developmental Disabilities as well as the Minnesota Adult Abuse Reporting Center (MAARC). The policy did not include contact information for the Office of Health Facility Complaints (OHFC) at the Minnesota Department of Health. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 570 SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	0 570		

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0 570	Continued From page 12 review, the licensee failed to display the original current license at the main entrance of the assisted living facility as required. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living license effective November 1, 2024, with an expiration of October 31, 2025, for a capacity of four residents. On August 12, 2024, at 9:40 a.m., the surveyor observed the licensee's walls and entry way and could not locate the assisted living license posted. Unlicensed personnel (ULP)-B stated it was on a table in the corner of the living room. The surveyor observed the original current license along with the licensee's previous license behind a pile of boxes which included the board game Battleship, Yahtzee, and a box of vinyl gloves. The license was not posted prominently. On August 13, 2024, at 11:52 a.m., clinical nurse supervisor (CNS)-A stated they knew their current assisted living license was required to be posted prominently. The surveyor observed CNS-A obtain the license from behind the boxes. CNS-A told licensed assisted living director (LALD)-D to post it on the wall near the door. The surveyor observed LALD-D post their current license prominently by the facility entrance under a wall	0 570		

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0 570	Continued From page 13 clock. The licensee's 2.04 Assisted Living License and Posting policy dated September 1, 2021, indicated, "Open Arms will maintain a current Assisted Living License issued by the Minnesota Department of Health. The issued license will be posted at the main entrance of the facility." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 570		
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	0 680		

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0 680	Continued From page 14 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 observation, interview, and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required content and to post it prominently in a conspicuous place for staff, residents, and visitors to view. 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 Emergency Preparedness Plan last updated on June 20, 2024, lacked evidence of the following required information: - documentation of the licensee's risk assessment; - all-hazards approach, including emerging infectious diseases (EID), as applicable; - categorization of the various probable risks/hazards by likelihood of occurrence; - development of strategies for addressing facility & community-based risks (i.e.: evacuation plans, staffing surges/shortages, back-up plans); - quarterly review of the missing resident plan; - designation of a qualified person, who is authorized in writing, to act in the absence of the	0 680		

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0 680	Continued From page 15 administrator; - identification of which staff would assume specific roles in another's absence through succession planning and delegation of authority. - development and implementation of EP policies/procedures (P/P) based on the EP, risk assessment & communication plan; - shelter in place needs; - development of P/P for at minimum food, water and pharmaceutical supplies; - development of P/P for sewage and waste disposal; - development of P/P for system to track the location of on-duty staff and sheltered residents; - development of P/P for if on-duty staff and sheltered residents are relocated, how the licensee must document the specific name/location of the receiving facility or other location; - development of P/P to address safe evacuation from the facility, including consideration of care/treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); primary/alternate communication means with external sources of assistance; - development of P/P for a system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records; - development of P/P to address: use of volunteers, including the process/role for integration; - development of a communication plan to include all of the following: method for sharing information from the emergency plan, that the facility has determined appropriate, with residents and their families/representatives; and -development of a communication plan which included:	0 680		

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0 680	Continued From page 16 -method for sharing information and medical documentation for residents under the facility's care, as necessary, with other HCPs to maintain continuity of care -means, in event of evacuation, to release resident information as permitted under 45 CFR 164.510(b)(1)(ii) -means of providing information about general condition/ location of residents under the facility's care as permitted under 45 CFR 164.510(b)(4). On August 13, 2024, at 11:45 a.m., the surveyor reviewed the EPP with licensed assisted living director (LALD)-D and clinical nurse supervisor (CNS)-A. Both stated their EPP was incomplete and was not fully tailored to the licensee. The licensee's Emergency Preparedness* policy, dated February 15, 2023, indicated: "Policy Statement: [Licensee] will have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. The plan considers the organization's commitment to provide services while ensuring the safety of its employees and residents. Open Arms Group Home will implement the Emergency Management program* as soon as the agency becomes aware of the existence of an emergency." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record	0 730		

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0 730	Continued From page 17 Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and	0 730		

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0 730	Continued From page 18 any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the resident record included documentation of all services provided for two of two residents (R2, R3). 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: R2 R2 was admitted to the licensee on February 6, 2023. R2's Service Plan effective April 27, 2023, indicated R2 received services for activity assistance, appointment reminders/assistance, dressing AM and PM, finance management, grooming, housekeeping, laundry, linen change, manage behavior-agitation, manage behavior-anxiety, manage behavior-physical aggression, manage behavior-property destruction, manage behavior-verbal aggression, meal assistance, medication administration,	0 730		

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0 730	Continued From page 19 safety checks, shopping assistance, socialization, and transportation assistance. R2's Service Recap Summary for August 2024, lacked documentation services were provided on the following days: - activity assistance, August 1-5, 8-11, 2024; - dressing AM, August 1-5, 8-11, 2024; - dressing PM, August 2, 3, 9 and 10, 2024; - finance management on August 1-5, 8-11, 2024; - grooming on August 1-5, 8-11, 2024; - housekeeping on August 1-5, 8-11, 2024; - laundry, was not on the recap summary and not being documented; - manage behavior-agitation PM, August 2, 3, 9 and 10, 2024; - manage behavior-anxiety PM, August 2, 3, 9 and 10, 2024; - manage behavior-physical aggression PM, August 2, 3, 9 and 10, 2024; - manage behavior-property destruction PM, August 2, 3, 9 and 10, 2024; - manage behavior-verbal aggression PM, August 2, 3, 9 and 10, 2024; - manage behavior-agitation overnight, August 2-7, 9-11, 2024; - manage behavior-anxiety overnight, August 2-7, 9-11, 2024; - manage behavior-physical aggression overnight, August 2-7, 9-11, 2024; - manage behavior-property destruction overnight, August 2-7, 9-11, 2024; - manage behavior-verbal aggression overnight, August 2-7, 9-11, 2024; - meal assistance AM on August 1-5, 8-11, 2024; - meal assistance midday, August 1-6, 8-11, 2024; - meal assistance PM, August 2, 3, 9 and 10, 2024; - medication administration 8:00 a.m., August	0 730		

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0 730	Continued From page 20 2-5, 8-11, 2024; - medication administration 12:00 p.m., August 1-5, 8-11, 2024; - medication administration 4:00 p.m., August 2-5, 8-10, 2024; - medication administration 5:00 p.m., August 2-5, 8-10, 2024; - medication administration 8:00 p.m., August 2-5, 8-10, 2024; - safety checks AM, August 1-5, 8-11, 2024; - safety checks PM, August 2, 3, 9 and 10, 2024; - safety checks overnight, August 2-7, 9-11, 2024; - shopping assistance, was not on the recap summary and was not being documented; - socialization, August 1-5, 8-11, 2024; and - transportation assistance, was not on the recap summary and was not being documented. On August 12, 2024, at 9:53 a.m., the surveyor observed unlicensed personnel (ULP)-B provide grooming services for R2. On August 13, 2024, at 8:25 a.m., the surveyor observed ULP-B administer medication for R2. On August 12, 2024, R2 stated the licensee provided their services. R3 R3 was admitted to the licensee on June 4, 2021. R3's Service Plan effective April 27, 2023, indicated R3 received services for activity assistance, appointment reminders/assistance, bathing reminders, dressing AM and PM, finance management, grooming, housekeeping, laundry, linen changes, meal assistance, manage wandering symptoms, meal assistance, medication administration, safety checks,	0 730		

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0 730	Continued From page 21 shopping assistance, socialization and transportation assistance. Also managing behaviors including agitation, anxiety, physical aggression, repetitive, self-injurious and verbal aggression. R3's Service Recap Summary for August 2024, lacked documentation services were provided on the following days: - activity assistance, August 1-5, 8-11, 2024; - bathing assistance PM, August 2, 3, 7, 9 and 10, 2024; - dressing AM, August 1-5, 8-11, 2024; - dressing PM, August 2, 3, 7, 9 and 10, 2024; - finance management on August 1-5, 8-11, 2024; - grooming on August 1-5, 8-11, 2024; - housekeeping on August 1-5, 8-11, 2024; - laundry, was not on the recap summary and was not being documented; - manage behavior-agitation PM, August 2, 3, 7, 9 and 10, 2024; - manage behavior-anxiety PM, August 2, 3, 7, 9 and 10, 2024; - manage behavior-physical aggression PM, August 2, 3, 7, 9 and 10, 2024; - manage behavior-repetitive PM, August 2, 3, 7, 9 and 10, 2024; - manage behavior-self injurious PM, August 2, 3, 7, 9 and 10, 2024; - manage behavior-verbal aggression PM, August 2, 3, 7, 9 and 10, 2024; - manage symptoms -wandering PM, August 2, 3, 7, 9 and 10, 2024; - manage behavior-agitation overnight, August 2-6, 8-11, 2024; - manage behavior-anxiety overnight, August 2-6, 8-11, 2024; - manage behavior-physical aggression overnight, August 2-6, 8-11, 2024; - manage behavior-repetitive overnight, August	0 730		

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0 730	Continued From page 22 2-6, 8-11, 2024; - manage behavior-self injurious overnight, August 2-6, 8-11, 2024; - manage behavior-verbal aggression overnight, August 2-6, 8-11, 2024; - manage symptoms -wandering overnight, August 2-6, 8-11, 2024; - meal assistance AM on August 1-5, 8-11, 2024; - meal assistance midday, August 1-6, 8-11, 2024; - meal assistance PM, August 2, 3, 7, 9 and 10, 2024; - medication administration 8:00 a.m., August 2-5, 8-11, 2024; - medication administration 12:00 p.m., August 1-5, 8-11, 2024; - medication administration 4:00 p.m., August 2-5, 8-10, 2024; - medication administration 5:00 p.m., August 2-5, 8-10, 2024; - medication administration 8:00 p.m., August 2-5, 8-10, 2024; - safety checks AM, August 1-5, 8-11, 2024; - safety checks PM, August 2, 3, 9 and 10, 2024; - safety checks overnight, August 2-7, 8-11, 2024; - shopping assistance, was not on the recap summary and was not being documented; - socialization, August 1-5, 8-11, 2024; and - transportation assistance, was not on the recap summary and was not being documented. On August 13, 2024, at 8:40 a.m., ULP-B stated they were trained on how to document service administration by clinical nurse supervisor (CNS)-A. ULP-B stated they document administered services in RTask (charting software) but also sometimes document on paper and would provide the paper logs for the surveyor to review.	0 730		

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0 730	Continued From page 23 On August 13, 2024, at 10:40 a.m., CNS-A acknowledged R2 and R3's missing service documentation. On August 13, 2024, at 10:58 a.m., CNS-A brought paper documentation of R2's medication administration record (MAR) but no paper service log. CNS-A stated some staff had been documenting on paper without their knowledge. Licensed assisted living director (LALD)-D stated some of the staff didn't understand how to use RTask. CNS-A stated if this were the case then they needed to know about it so they could retrain them. On August 13, 2024, at 1:55 p.m., CNS-A stated R2 and R3's records lacked documented services. CNS-A stated their staff were educated and trained but they still were not completing documentation. The licensee's 7.22 Medication & Treatment Record - Documentation & Refusal policy dated August 1, 2021, indicated, " [Licensee] will create and maintain a correct and accurate medication and/or treatment/therapy record for each resident receiving medication assistance or administration and or treatments and therapies." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter	0 780		

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0 780	Continued From page 24 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that functioned and are interconnected so that the actuation of one alarm causes all alarms in the dwelling unit to actuate. 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	0 780		

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	36675	A. BUILDING: _____ B. WING _____	08/13/2024

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0 780	Continued From page 25 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the facility tour on August 12, 2024, with the clinical nurse supervisor (CNS)-A, between 12:00 p.m. and 2:00 p.m. the following deficient conditions were observed: The surveyor observed when the smoke alarms were push button tested by the CNS-A, some of the alarms did not operate. All the smoke alarms in the residence where not interconnected. The surveyor explained to the CNS-A, that 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. The deficient condition was visually verified by the CNS-A accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest	0 790		

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0 790	Continued From page 26 fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the facility tour on August 12, 2024, with the clinical nurse supervisor (CNS)-A, between 12:00 p.m. and 2:00 p.m. the following deficient condition were observed: The portable fire extinguishers throughout the facility were not mounted. The surveyor explained to the CNS-A that all fire extinguishers shall be mounted to meet the state fire code requirements. The deficient condition was visually verified by the CNS-A accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7)	0 790		

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0 790	Continued From page 27 days.	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a 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: During the facility tour on August 12, 2024, with the clinical nurse supervisor (CNS)-A, between 12:00 p.m. and 2:00 p.m. the following deficient conditions were observed:	0 800		

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0 800	Continued From page 28 LOCK ON BASEMENT DOOR: The surveyor observed a lock on the basement door that will lock individuals in. The surveyor explained to CNS-A, egress doors shall be readily openable from the egress side without the use of a key or special knowledge or effort. RESIDENT ROOM 4: The surveyor observed the crank/handle on the emergency escape window in resident room 4 was broken and not fully operable. The surveyor explained to CNS-A the emergency escape and rescue openings shall be operational from inside the room without the use of keys or tools. The deficient conditions were visually verified by the CNS-A accompanying on the tour. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for	0 810		

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0 810	Continued From page 29 residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive	0 810		

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0 810	Continued From page 30 or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: A record review and interview were conducted on August 12, 2024, at approximately 1:30 p.m. with the clinical nurse supervisor (CNS)-A on the fire safety and evacuation plan and fire safety and evacuation training and drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The fire safety and evacuation plan failed to include the following: The fire safety and evacuation plan 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 plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but the plan was designed for a building with life safety systems such as fire doors and smoke compartments. The policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which did not have life safety systems or a fire-resistant construction type. The fire safety and evacuation plan 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.	0 810		

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0 810	Continued From page 31 The fire safety and evacuation plan 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. The fire safety and evacuation map were not posted anywhere in the facility. During an interview on August 12, 2024, CNS-A stated they will review and make changes/additions to the plan and that they will get the maps posted and put in the fire safety and evacuation plan binder and that it would be always available. TRAINING: Record review indicated the licensee failed to provide evacuation training to residents at least once per year. CNS-A was unable to provide documentation showing any training offered or training scheduled for a future date for residents on the fire safety and evacuation plan. Record review indicated the licensee failed to provide training to employees on the fire safety and evacuation plan upon hire and at least twice per year. CNS-A was unable to provide documentation showing any training provided or training scheduled for a future date. During an interview on August 12, 2024, CNS-A stated they will start to complete the required training.	0 810		

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0 810	Continued From page 32 DRILLS: Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. During an interview on August 12, 2024, CNS-A stated they will start doing the evacuation drills and understood the requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
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 of the residents and staff.	0 820	This immediate correction order identified on August 12, 2024, has had the immediacy lifted as of August 13, 2024, however non-compliance remained a	

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0 820	Continued From page 33 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 a limited number of staff are involved or the situation has occurred only occasionally). Findings include: On a facility tour on August 12, 2024, at 12:30 p.m. with (LALD)-D, it was observed that compliant emergency escape and rescue openings were not provided in resident sleeping room 2. Occupied Resident Room Resident sleeping room 2 emergency escape and rescue clear window opening measurements are 18 inches wide, 36 inches in height and 44 inches off the floor. This bedroom is on the upper level of the home. The windows do not meet the 648 inches minimum requirements for clear opening. The windows were measured with the LALD-D, and the surveyor present. It was explained to LALD-D that at least one compliant emergency escape and rescue opening is required within each resident sleeping room. Existing emergency escape and rescue openings are required to meet a minimum clear opening area of 648 square inches and have a minimum dimension of 20 inches in height and a minimum dimension of 20 inches in width. The windowsill height from the floor to the clear opening shall be	0 820	scope and level of G.	

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0 820	Continued From page 34 not more than 48 inches. These deficient conditions were visually verified by LALD-D accompanying on the tour. Surveyor explained that an immediate correction order was issued for the above findings. TIME PERIOD FOR CORRECTION: Immediate.	0 820		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures	01500		

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01500	Continued From page 35 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 access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received at least eight hours of annual training for each 12 months of employment on required annual training topics for two of two employees (clinical nurse supervisor (CNS)-A, unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01500		

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01500	Continued From page 36 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: CNS-A CNS-A was hired on June 22, 2020, to provide clinical duties and oversight to unlicensed personnel. CNS-A's employee records, and Educare (an online training platform) transcript, lacked annual training to include at least eight hours of annual training for every 12 months of employment for the following topics: -Reporting maltreatment of vulnerable adults or minors; -Assisted Living Bill of Rights; -Effective approaches to use to problems solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; -Review of provider's policies and procedures; -Principles of person-centered planning/service delivery; and -Hearing loss training (optional). ULP-B ULP-B was hired on October 1, 2021, to provide direct cares to residents. ULP-B's employee record, and Educare transcript, lacked annual training to include at least eight hours of training for every 12 months of employment in the following topics:	01500		

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01500	Continued From page 37 -Reporting maltreatment of vulnerable adults or minors; -Assisted Living Bill of Rights; -Effective approaches to use to problems solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; -Review of provider's policies and procedures; -Principles of person-centered planning/service delivery; and -Hearing loss training (optional). On August 12-13, 2024, the surveyor observed CNS-A performing their CNS duties throughout the survey. On August 13, 2024, at 8:25 a.m., the surveyor observed ULP-B administer medications to R2. On August 12, 2024, at 12:55 p.m., CNS-A stated they had not completed their own required annual training topics. CNS-A stated they must have overlooked completing their annual training. On August 13, 2024, at 8:20 a.m., ULP-B stated they had not completed all of the required annual training topics. On August 13, 2024, at 11:17 a.m., CNS-A stated they utilized Educare for all of their annual training. CNS-A stated they were in charge of making sure the annual training topics were assigned to staff. CNS-A stated they had been assigning the annual training topics to staff, but staff were not following through on completing them, and it was a problem they were having with all staff. The licensee's 5.06 Annual Required Staff	01500		

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01500	Continued From page 38 Training policy dated September 1, 2021, indicated: "The following training elements MUST be included every 12 months to all staff who performs direct care services: 1. Training on reporting of maltreatment of vulnerable adults under section 626.557 2. Review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights 3. Review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases 4. Effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders 5. Review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures 6. Principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. In addition to the topics listed above, annual training may also contain training on providing services to residents with hearing loss." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		

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	36675	A. BUILDING: _____ B. WING _____	08/13/2024

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01530 SS=D	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. 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 observation, interview, and record review, the licensee failed to provide employees with the initial eight (8) hours of dementia training within 160 hours of providing direct care to residents and two hours of annual dementia training for one of two direct care employees (unlicensed personnel (ULP)-B).	01530		

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01530	Continued From page 40 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-B was hired on October 1, 2021, to provide direct cares to residents. ULP-B's employee record, and Educare (an online training platform) transcript, lacked the required eight hours of initial dementia training and two hours of annual dementia training: ULP-B's Educare transcript included 7.5 hours of dementia training last completed on October 24 and 25, 2022. On August 13, 2024, at 8:25 a.m., the surveyor observed ULP-B administer medications to R2. On August 13, 2024, at 8:20 a.m., ULP-B stated they had not completed their dementia annual training topics. On August 13, 2024, at 11:17 a.m., clinical nurse supervisor (CNS)-A stated they utilized Educare for all of their orientation trainings and annual training. CNS-A stated they were in charge of making sure dementia training topics were assigned to staff. CNS-A stated they had been assigning required training topics to staff, but staff were not following through on completing them, and it was a problem they were having with all staff.	01530		

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01530	Continued From page 41 The licensee's 5.03 Dementia Training policy dated September 1, 2021, indicated, "Direct care employees will complete eight (8) hours of initial training within 160 hours of the employment start date." It further indicated, "All staff will complete two (2) hours of additional training for each 12 months of work thereafter." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
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 review medication administration instructions prior to administering medication one of two residents (R2). In addition, the licensee failed to document administration of	01760		

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01760	Continued From page 42 medication for two of two residents (R2, R3), and the licensee failed to discontinue medication upon receiving orders and to ensure the medication was removed from their prepackaged bubble packs for one of two residents (R3). 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: R2 and R3's medications were prepackaged by the pharmacy with all medications in one bubble on a blister pack for each time of the day. R2 R2 was admitted to the licensee on February 6, 2023. R2 had a diagnosis of autism. R2's Service Plan effective April 27, 2023, indicated R2 received services for medication administration. R2's Med Setup/Review Summary (medication administration record (MAR)) for July 2024, from RTask (documentation software) was provided with only page one of two. It was printed out and included electronic documentation for some of the medication administration dates between July 1-31, 2024, the remaining dates were written in by hand with the administrating staff members initials. The MAR had electronic medication	01760		

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01760	Continued From page 43 administration documentation on July 1-3, 11, 15-17, 21-25 and 28-31, 2024. The MAR had handwritten medication administration documentation on July 3-10, 12-22 and 25-31, 2024, with some dates overlapping with the electronic documentation. This indicated the handwritten dates were not documented at the time of administration. The MAR also lacked documentation for the following dates and times: -divalproex 500 milligram (mg) extended release (ER) tablet, take two tablets by mouth (PO) twice daily; missed documentation at 4:00 p.m., on July 1, 2024; -guanfacine 1mg tablet, take one tablet PO three times daily; missed documentation at 4:00 p.m., and 8:00 p.m., on July 1, 2024; -hydroxyzine hydrochloride (HCL) 50mg tablet, take one tablet PO every day at noon and with dinner; missed documentation at 12:00 p.m., and 5:00 p.m., on July 1, 2024; and -olanzapine 10mg tablet, take one tablet PO daily; missed documentation at 8:00 p.m., on July 1, 2024. R2's August 2024 MAR from RTask, with no handwritten documentation, indicated R2 took the following scheduled medications and lacked documentation for following dates and times: -divalproex 500mg ER tablet, take two tablets by mouth (PO) twice daily; missing documentation at 8:00 a.m., on August 2-5, 8-12, 2024, and 4:00 p.m., on August 2, 3, 9, 10 and 12, 2024; -escitalopram 20mg tablet, take one tablet PO daily; missing documentation at 8:00 a.m., on August 2-5, 8-12, 2024, and 4:00 p.m., and 8:00 p.m., on August 2, 3, 9, 10 and 12, 2024; -guanfacine 1mg tablet, take one tablet PO three times daily; missing documentation at 8:00 a.m., on August 2-5, 8-12, 2024; -hydroxyzine HCL 50mg tablet, take one tablet	01760		

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01760	Continued From page 44 PO every day at noon and with dinner; missed documentation at 12:00 p.m., on August 1, 3-5, 8-12, 2024; and -olanzapine 10mg tablet, take one tablet PO daily; missing documentation at 8:00 p.m., on August 2, 3, 9, 10, 12 and 13, 2024. On August 13, 2024, at 8:25 a.m., the surveyor observed unlicensed personnel (ULP)-B administer R2's 8:00 a.m. medications. ULP-B used the 8:00 a.m., prepackaged bubble pack which contained two divalproex 500mg ER tablets, one escitalopram 20mg tablet, one guanfacine 1mg tablet and one olanzapine 10mg tablet. ULP-B checked the prepackaged bubble pack for R2's name but did not perform further checks by comparing the medications to R2's MAR to ensure the correct medications were being administered. At no time was ULP-B observed reviewing the MAR during R2's medication administration. The surveyor observed ULP-B did not document R2's medication administration but instead, ULP-B sat down on the couch. After a few minutes, the surveyor observed ULP-B still had not documented R2's medication administration, so the surveyor inquired if ULP-B was going to document R2's medication administration. ULP-B then showed the surveyor where they document medication administration on a work phone. At that time, the surveyor observed ULP-B document administration of divalproex, escitalopram and guanfacine; ULP-B did not document olanzapine was administered. R2's MAR indicated olanzapine was supposed to be administered at 8:00 p.m. ULP-B stated they were trained by CNS-A to review the MAR prior to administration and to document immediately after administering medication. ULP-B stated they did not document the administration right away as	01760		

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01760	Continued From page 45 they should have. On August 13, 2024, at 8:40 a.m., ULP-B stated they only checked R2's name on the prepackaged bubble pack prior to administering R2's medication and did not verify the medication with R2's MAR in RTask. ULP-B stated they must have missed documenting R2's olanzapine when they administered it at 8:25 a.m. ULP-B stated some of their documentation was on paper and would find those logs for the surveyor. R3 R3 was admitted to the licensee on June 4, 2021. R3 had diagnoses of bipolar and schizoaffective disorder. R3's Service Plan effective April 27, 2023, indicated R3 received services for medication administration. R3's August 2024 Medication Administration Summary from RTask indicated R3 took the following scheduled medications and lacked documentation for the following dates and times: -clonazepam 1mg tablet; take one tablet PO daily; missed documentation at 8:00 a.m., on August 1, 3-5 and 8-12, 2024; -docusate sodium 100mg capsule; take two capsules PO twice daily; missed documentation at 8:00 a.m., on August 1, 3-5 and 8-12, 2024, and at 8:00 p.m., on August 2, 3, 7, 9, 10 and 12, 2024; -vitamin D 5000 unit (u) capsule; take two capsules PO daily; missed documentation at 8:00 a.m., on August 1, 3-5 and 8-12, 2024; -haloperidol 20mg tablet, take one tablet PO daily; missed documentation at 8:00 p.m., on	01760		

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01760	Continued From page 46 August 2, 3, 7, 9, 10 and 12, 2024; -haloperidol 5mg tablet, take one tablet PO daily with 20mg tablet; missed documentation at 8:00 p.m., on August 2, 3, 7, 9, 10 and 12, 2024; -lamotrigine 100mg tablet, take one tablet PO at bedtime; missed documentation at 8:00 p.m., on August 2, 3, 7, 9, 10 and 12, 2024; -lithium 300mg, one tablet PO at bedtime; not included on the MAR, no documentation of administration; and -olanzapine 10mg tablet, take one tablet PO at bedtime; missed documentation at 8:00 p.m., on August 2, 3, 7, 9, 10 and 12, 2024. R3's Behavioral Health Follow-Up (after visit summary (AVS)) dated April 3, 2024, indicated R3 was prescribed the following medication: -benztropine 2mg tablet, take one tablet two times daily to treat side effects of psychiatric medication; and -lithium carbonate ER 300mg, take two tablets PO at bedtime for schizoaffective disorder. R3's New Medication/Treatment Orders dated April 18, 2024, included the following order: -change the way you take lithium to 300mg, one tablet PO at bedtime. R3's New Medication/Treatment Orders dated June 19, 2024, indicated to discontinue benztropine. On August 13, 2024, at 12:22 p.m., the surveyor observed R3's prepackaged bubble packs with CNS-A which indicated R3's bedtime prepackaged bubble pack included the following medications which were not on R3's August 2024, MAR: -benztropine 1mg tablet, take one tablet two times daily (this dose was different from the order	01760		

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01760	Continued From page 47 written on April 3, 2024, which was for 2mg tablets two times daily); and -lithium carbonate ER 300mg, take one tablet PO at bedtime. On August 13, 2024, at 10:40 a.m., the surveyor explained to CNS-A they observed ULP-B administer R2's medication on August 13, 2024, at 8:25 a.m. The surveyor explained to CNS-A R2's olanzapine was in the prepackaged bubble pack for 8:00 a.m., but the MAR indicated it should have been administered in the evening at 8:00 p.m., and ULP-B did not document R2's olanzapine as given. CNS-A stated they would address the olanzapine order and clarify the time of day it should be given. CNS-A stated R2 and R3's MAR were missing medication administration documentation. CNS-A stated they had concerns about their ULPs checking the MAR in RTask prior to administering medications, the surveyor explained they observed ULP-B administer R2's medication at 8:25 a.m., and ULP-B did not check the MAR in RTask prior to administering the medications. CNS-A stated they didn't know what to do anymore. CNS-A stated they educated the ULP's over and over again, but they continued to not check the MAR in RTask prior to administering medications. On August 13, 2024, at 10:58 a.m., CNS-A brought the surveyor the printed July 2024 MAR for R2. CNS-A stated, without their knowledge, some staff had been putting their medication administration documentation on paper and not using RTask. Assisted living director (ALD)-D stated some of their ULPs didn't understand how to use RTask. CNS-A stated if staff required help learning how to use Rtask then they needed to notify them (CNS-A) so staff could be retrained. CNS-A did not have an explanation as to how	01760		

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01760	Continued From page 48 handwritten documentation could have been completed in real time if the July 2024 MAR was printed with electronic charting completed through the end of the month. On August 13, 2024, at 12:22 p.m., the surveyor reviewed R3's August 2024 MAR, medication orders and pills in the prepackaged bubbles packs with CNS-A. CNS-A stated R3's benztropine was not being documented because it had been discontinued and would provide the discontinue order for the surveyor. The surveyor explained benztropine was still in the prepackaged bubble packs. CNS-A stated, "how do you know staff haven't been taking it out and not giving it?" in reference to the benztropine. The surveyor inquired if they had documentation of the benztropine being removed and disposed of. CNS-A would not provide an answer. ALD-D stated they thought the benztropine had been discontinued and thought the staff were taking it out of the prepackaged pill pack. ALD-D called ULP-B on the phone and stated ULP-B had not been administering the benztropine and had been removing it from the prepackaged pill pack; ULP-B told ALD-D they had not been documenting it was being removed. CNS-A stated they did not know benztropine was still in the prepackaged pill packs and could not be certain whether or not it was given or removed from the prepackaged pill pack by ULP's. The surveyor inquired who was disposing of the benztropine if staff were removing it fom the prepackaged pill pack. CNS-A did not respond with an answer to the question. CNS-A stated both benztropine and lithium were currently being administered for R3 but were not being documented on the MAR. CNS-A stated a medication reconciliation was needed for their residents.	01760		

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01760	Continued From page 49 The licensee's 7.22 Medication & Treatment Record - Documentation & Refusal policy dated August 1, 2021, indicated: "POLICY: [Licensee] will create and maintain a correct and accurate medication and/or treatment/therapy record for each resident receiving medication assistance or administration and or treatments and therapies. PROCEDURE: 1) The following must be documented in the resident's medication and/or treatment/therapy records after providing medication assistance or administration: a. The date, b. The time, c. The quantity of dosage, d. The method of administration of all prescribed legend and over-the-counter medications and or treatments/therapy e. Signature and title of the authorized person who provided the assistance and/or administration of medications/treatment/therapy 2) If medication and or treatment/therapy assistance and/or administration were not completed as prescribed, documentation must include the reason why it was not completed and any follow up procedures that were provided. 3) Documentation of medication/treatment/therapy reminders, medication/treatment/therapy assistance or medication/treatment/therapy administration will be completed by the person who performed the task immediately after the medication assistance/administration is completed. 4) Document special occurrences as follows: a. Medication and/or Treatment/Therapy Refused - To indicate the medication/treatment was refused, circle your initials and write a capital R in the same box on the MAR or TAR form. b. Medication/Treatment/Therapy Held - To	01760		

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01760	Continued From page 50 indicate the medication/treatment was held, circle your initials and write a capital Hin the same box on the MAR or TAR form. c. There is an area on the reverse side of the MAR from marked "Special Remarks." This is the designated area to document the reason for refusal, held, PRN given, etc. 5) A signature page must be filled out if using initials for verification. The signature page will include name, initials, title and signature. 6) [Name of AL] (sic) will document in the resident's record any refusal for an assessment for medication management by the resident. The facility must discuss with the resident the possible consequences of the resident's refusal and document the discussion in the resident's record." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01820		

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01820	Continued From page 51 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted to the licensee on February 6, 2023. R2's Service Plan effective April 27, 2023, indicated R2 received services for medication administration. R2's medications were prepackaged by the pharmacy with all medications in one bubble on a blister pack for each time of the day. R2's E-Script New Prescription Request forms, with various electronic signature dates, indicated R2 was prescribed: -Ativan 0.5 milligram (mg) tablet; take one tablet daily for severe anxiety; signed on July 5, 2023; and -trazodone 150mg tablet, take one tablet by mouth (PO) daily at bedtime; signed on January 1, 2024. R2's August 2024 Medication Administration Summary (MAR) from Rtask (charting software) did not include Ativan or trazodone. R2's prepackaged bubble packs did not contain Ativan or trazodone. R2's record lacked a discontinue order for Ativan and trazodone. On August 13, 2024, at 8:25 a.m., the surveyor	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36675	A. BUILDING: _____ B. WING _____	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS GROUP HOME LLC	3701 66TH AVENUE NORTH BROOKLYN CENTER, MN 55429

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01820	Continued From page 52 observed unlicensed personnel (ULP)-B administer R2's 8:00 a.m. medications. ULP-B used the 8:00 a.m. prepackaged bubble pack which contained two divalproex 500mg ER tablets, one escitalopram 20mg tablet, one guanfacine 1mg tablet and one olanzapine 10mg tablet. On August 13, 2024, at 10:40 a.m., CNS-A stated R2's Ativan and trazodone were not on R2's August 2024 MAR as they were discontinued, and they would provide the discontinue orders to the surveyor. On August 13, 2024, at 12:22 p.m., CNS-A stated they could not find discontinue orders for Ativan or trazodone. The licensee's 7.20 Medication & Treatment Orders policy dated August 1, 2021, indicated: "1) The RN is responsible for assuring that: a. current, authorized prescriber orders for medications or treatments administered by the staff are kept on file in the residents' records b. communicated to the resident or responsible party c. educates resident or responsible party on all medication and treatment orders, and d. changes in orders are addressed in the resident's service plan and are communicated to the other staff. 2) An order for medication or treatment must contain the name of the resident, a description of the medication, treatment or therapy to be provided and the frequency, duration, and other information needed to carry out the order. 3) An order for medication or treatment must be dated, signed by the prescriber and must be current and consistent with the resident's nursing assessment.	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36675	A. BUILDING: _____ B. WING _____	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS GROUP HOME LLC	3701 66TH AVENUE NORTH BROOKLYN CENTER, MN 55429

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01820	Continued From page 53 4) Upon receiving verbal orders or unsigned electronic orders, a licensed nurse will record and sign the order and forward the written order to the prescriber for a signature after receipt of the verbal or electronic order. The licensed nurse will continue to follow-up with the prescriber's office until the signature is received. 5) The licensed nurse will communicate with the prescriber to assure that the prescriber renews a medication or treatment/therapy order at least every 12 months, or more frequently as needed. 6) The licensed nurse will review all medication and treatment orders for progress, effectiveness and necessity on a regular basis and with resident change of condition. 7) The license nurse will also monitor and evaluate medication and treatment/therapy orders and services for effectiveness on a regular basis. 8) A residents MAR and TAR will be audited regularly by licensed nurse or designee for documentation compliance." 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 prescription	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36675	A. BUILDING: _____ B. WING _____	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS GROUP HOME LLC	3701 66TH AVENUE NORTH BROOKLYN CENTER, MN 55429

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01880	Continued From page 54 medication securely to permit only authorized personnel to have access for one of three residents (R3). 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: R3 was admitted to the licensee on June 4, 2021. R3's Service Plan effective April 27, 2023, indicated R3 received services for medication administration. On August 13, 2024, at 8:15 a.m., upon entry to the facility the surveyor immediately observed two bottles of medication on the coffee table in the middle of the living room. One was an orange prescription bottle and the second appeared to be a vitamin or supplement bottle. On August 13, 2024, at 8:20 a.m., the surveyor and R2 were left alone with the two bottles of medication on the coffee table while unlicensed personnel (ULP)-B made R2's breakfast in the kitchen, the kitchen was out of the sight line of the coffee table. On August 13, 2024, at 8:31 a.m., ULP-B stated the bottles of medication belonged to R3. ULP-B stated they administered R3 their medication	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36675	A. BUILDING: _____ B. WING _____	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01880	Continued From page 55 earlier in the morning but had not put the medication away yet. The surveyor explained medications could not be left unattended. ULP-B stated, "would it matter if they were out if they were still within eyesight?" The surveyor explained they observed ULP-B going in and out of the room since the surveyor's arrival and observed ULP-B out of the room in the kitchen cooking R2's breakfast. The medications were identified as: -R3; docusate sodium 100mg capsules, take two capsules by mouth (PO) twice daily as needed (PRN) for constipation; and -R3; FertilAid for Men dietary supplement. On August 13, 2024, at 8:40 a.m., ULP-B stated R3's medications were not left on their own on the coffee table and were within ULP-B's eyesight at all times. The surveyor explained ULP-B was observed going in and out of the living room on multiple occasions while making R2's breakfast. The surveyor stood at the coffee table with ULP-B and inquired if ULP-B could see into the kitchen. ULP-B stated they could not. The licensee's 7.11 Medication Storage policy dated August 1, 2021, indicated, "When medications are managed and stored by [licensee] medications will be kept securely locked and stored per manufacturer's 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
Saint Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *08/13/24*
Time: 10:45:00
Report: 1005241187

Food and Beverage Establishment Inspection Report

Location:
Open Arms Group Home Llc
3701 66th Avenue North
Brooklyn Center, MN55429
Hennepin County, 27

Establishment Info:
ID #: 0037676
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7632914880
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.

2-200 Employee Health

2-201.11C ***** Priority 1 *****

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.

THERE WAS NO EMPLOYEE ILLNESS LOG ON SITE. DISCUSSED RECORDING AND EXCLUSION REQUIREMENTS FOR EMPLOYEES ILL WITH VOMITING OR DIARRHEA. A BLANK LOG WAS LEFT ON SITE.

Comply By: 08/13/24

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) ***** Priority 1 *****

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

RAW SHELL EGGS WERE STORED ON THE TOP SHELF OF THE REFRIGERATOR. STORE RAW ANIMAL FOODS IN THE BOTTOM OF THE REFRIGERATOR TO PREVENT CROSS-CONTAMINATION OF READY-TO-EAT FOODS.

Comply By: 08/13/24

3-500B Microbial Control: hot and cold holding

3-501.16A2 ***** Priority 1 *****

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

TCS FOODS IN THE REFRIGERATOR WERE ABOVE 41 DEGREES F. UNIT WAS TURNED TO A COLDER SETTING. MONITOR TO ENSURE FOOD TEMPERATURES COME TO 41 DEGREES F

OR BELOW.
Comply By: 08/13/24

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.
OPENED MILK IN THE REFRIGERATOR WAS NOT DATE MARKED. DISCUSSED MARKING THE DAY THAT TCS FOODS ARE OPENED, TO ENSURE THEY ARE USED OR DISCARDED WITHIN 7 DAYS. FACT SHEET LEFT ON SITE.
Comply By: 08/13/24

4-300 Equipment Numbers and Capacities
4-302.13B ***** Priority 2 *****
MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.
THERE IS NO DEVICE ON SITE TO MEASURE THE UTENSIL SURFACE TEMPERATURE IN THE DISHWASHER. PROVIDE TEMPERATURE STRIPS OR A MAXIMUM REGISTERING THERMOMETER TO VERIFY THAT THE UTENSIL SURFACE TEMPERATURE IS 160 DEGREES F OR ABOVE.
Comply By: 08/20/24

Surface and Equipment Sanitizers

Utensil Surface Temp.: = at 160+ Degrees Fahrenheit
Location: DISHWAHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/MILK
Temperature: 47 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR
Violation Issued: Yes

Process/Item: Cold Hold/HUMMUS
Temperature: 48 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR
Violation Issued: Yes

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

INSPECTION COMPLETED WITH NURSE ON SITE AND REVIEWED WITH HRD NURSING EVALUATOR JOEY KEEN.

DISCUSSED DATE MARKING, GLOVE USE, COOKING TEMPERATURES, CROSS-CONTAMINATION, AND EMPLOYEE ILLNESS.

Type: Full
Date: *08/13/24*
Time: 10:45:00
Report: 1005241187
Open Arms Group Home Llc

Food and Beverage Establishment Inspection Report

INSPECTOR LEFT THERMOLABELS ON SITE AND AFTER INSPECTION OPERATOR SENT INSPECTOR A PICTURE OF THE TEMPERATURE STRIP THEY RAN THROUGH THEIR DISHWASHER, WHICH SHOWED IT PROVIDED A UTENSIL SURFACE TEMPERATURE OF 160+ DEGREES F.

KITCHEN IS RESIDENTIAL AND FOOD IS PREPARED FOR SAME DAY SERVICE.

FLOORING IS WOOD, CABINETS ARE WOOD WITH HOLLOW BASE, COUNTERS ARE LAMINATE, AND CEILING HAS A POPCORN FINISH. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

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 1005241187 of 08/13/24.

Certified Food Protection Manager: LESLIE A. HUNA

Certification Number: FM108954 Expires: 12/22/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
LESLIE HUNA

Signed: _____
Jessica Davis
Public Health Sanitarian III
651-201-3961
jessica.davis@state.mn.us