Electronically Delivered

April 15, 2025

Licensee
Open Arms LLC
14737 Innsbrook Lane
Burnsville, MN 55306

RE: Project Number(s) SL35020016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 18, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

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:

St - 0 - 0340 - 144g.30 Subd. 5 - Correction Orders - $500.00
St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00
St - 0 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $2,000.00**. 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

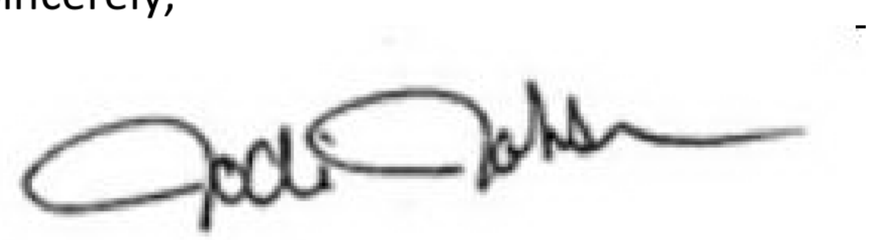
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms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



Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35020	A. BUILDING: _____ B. WING _____	03/18/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL35020016-0 On March 17, 2025, through March 18, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were five residents; five receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 340 SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever	0 340		

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0 340	Continued From page 1 the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must: (1) document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed provide documentation with actions taken to comply with correction orders from a survey completed on June 15, 2022. The lack of action to ensure compliance with regulations had the potential to affect all residents receiving services from the licensee. 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	0 340		

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0 340	Continued From page 2 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: INTERCONNECTED SMOKE ALARMS: During a survey that was conducted June 15, 2022, the licensee was cited using the 0780-tag identification number for failing to provide interconnected smoke alarms throughout the facility. On March 18, 2025, survey staff confirmed the deficient condition remained, as the facility smoke alarms were not interconnected. ANNUAL SERVICE OF FIRE EXTINGUISHERS: During a survey that was conducted June 15, 2022, the licensee was cited using the 0790-tag identification number for failing to provide annual service of the fire extinguishers and for failing to provide monthly inspections of the fire extinguishers by facility staff. On March 18, 2025, survey staff confirmed the deficient condition remained, as the licensee failed to provide annual service of the fire extinguishers and failed to maintain documentation of monthly inspections of the fire extinguishers. FIRE SAFETY AND EVACUATION PLAN: During a survey that was conducted June 15, 2022, the licensee was cited using the 0810-tag identification number for failing to provide a fire	0 340		

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0 340	Continued From page 3 safety and evacuation plan (FSEP) that included resident procedures for evacuation, for failing to provide training of staff on the FSEP at time of hire and at least twice per year after. On March 18, 2025, survey staff confirmed the deficient condition remained, as the licensee failed to provide a FSEP that included resident procedures for evacuation, for failing to provide training of staff on the FSEP at time of hire and at least twice per year after. INTERVIEW: The surveyor conducted an interview on March 18, 2025, with licensed assisted living director (LALD)-A. LALD-A stated new smoke alarms were installed in the facility that were capable of being interconnected. LALD-A stated they were not sure why the new smoke alarms were not interconnected at the time of survey. LALD-A stated the fire extinguishers had been replaced after the last survey. When asked about the annual service and monthly inspection, LALD-A stated that they have not performed or completed monthly inspections or annual service of the fire extinguishers since installation. LALD-A stated the FSEP was a third-party policy that had not been customized to fit the facility's needs. LALD-A stated they lacked documentation indicating staff were trained upon hire and twice per year thereafter on the FSEP. LALD-A stated	0 340		

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0 340	Continued From page 4 that staff training was done through Educare and not on the facilities FSEP. LALD-A stated that staff are trained on the facilities FSEP staff meetings. LALD-A said that they needed to find the meeting minutes and would email them to the provide no later than the morning of March 19, 2025. No email was received by the surveyor as of 12:00 p.m. on March 20, 2025. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570;	0 480		

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0 480	Continued From page 5 (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a	0 480		

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0 480	Continued From page 6 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 document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated March 18, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 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. (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	0 510		

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0 510	Continued From page 7 review, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control. 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 residents). The findings include: On March 17, 2025, at 11:00 a.m., the surveyor observed the lower-level common area bathroom contained a terry cloth bath towel folded and sitting on top of the seat of a commode. The surveyor observed both the upper-level and lower-level common area bathrooms lacked disposable paper towels to dry hands. On March 8, 2025, at 10:05 a.m., housing manager (HM)-B stated the bathroom should contain paper towels and if the residents ask for them, we will provide them. The Center for Disease Control (CDC) About Hand Hygiene for Patients in Healthcare Settings dated February 27, 2024, under recommendations and reports, indicates using disposable towels to dry hands after hand hygiene. The licensee's Infection Control policy dated January 10, 2022, indicated the licensee will observe the recommended precautions for assisted living as identified by the CDC.	0 510		

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0 510	Continued From page 8 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain documentation of quality management activity appropriate to the size and relevant to the type of services provided by the assisted living. This had the potential to affect all residents receiving assisted living 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	0 580		

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0 580	Continued From page 9 or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on March 17, 2025, at 9:30 a.m., the surveyor requested the minutes from the license's quality management meetings. The licensee provided a document dated March 6, 2025, labeled Quality Management Committee Meeting (sample agenda) and a list of potential agenda items. The document did not contain any minutes for the meeting. On March 17, 2025, at 1:30 p.m., the surveyor reviewed the quality management binder with housing manager (HM)-B. HM-B stating the quality management binder contained minutes for 2022, but not for 2023, 2024, or 2025. HM-B stated she was not sure if the transitioning of moving rooms they may be somewhere else. The licensee's Quality Improvement policy dated January 10, 2022, indicated documentation of quality improvement activities is maintained and updated as needed, but not less than annually and maintained for at least two years and will be provided to the commissioner at the time of survey, investigation or renewal as requested. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c	0 640		

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0 640	Continued From page 10 The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support protection and safety by not posting information the 911 emergency number in common areas and near telephones provided by the assisted living facility. This 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) 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 residents). The findings include: On March 17, 2025, at 10:00 a.m. during the facility tour with licensed assisted living director (LALD)-A, the 911 emergency number was not observed to be posted in common areas and near telephones provided by the assisted living	0 640		

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0 640	Continued From page 11 facility. LALD-A and housing manger (HM)-B stated they recently moved rooms and furniture and think the sign is posted behind the large file cabinet in the office. HM-B stated she was unaware the posting was required to be posted in a common area. No further information was provided TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a TB (tuberculosis) prevention and control program based on the most current guidelines issued by the centers for Disease Control and Prevention	0 660		

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	35020	A. BUILDING: _____ B. WING _____	03/18/2025

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0 660	Continued From page 12 (CDC) guidelines and the Minnesota Department of Health (MDH). The licensee failed to ensure one of one unlicensed personal (ULP)-C was screened for active TB and retained documentation in the employee's file. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-C was hired on March 12, 2025, to provide direct care under the licensee's assisted living license. On March 17, 2025, at 12:10 p.m., the surveyor observed ULP-C administering medications to R4. ULP-C's employee record contained a document labeled Result trends and dated December 27, 2022. The document indicated ULP-C had completed a TB QuantiFERON test on December 27, 2022, and was negative. ULP-C's employee record failed to show evidence of a TB screening completed at the time of hire or a more current TB test. On March 18, 2025, at 11:00 a.m., licensed assisted living director (LALD)-A stated she thought ULP-C had testing and symptom	0 660		

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0 660	Continued From page 13 screening from a previous employer and was unaware the testing could not be older than 90 days. The licensee's Tuberculosis Screening/Prevention policy dated January 10, 2022, indicated employees will receive a baseline TB screening upon hire to test for infection. The baseline screening includes an assessment for TB history and current TB symptoms. The MDH guidelines, "Regulations for Tuberculosis Control in Minnesota Health Care Settings" dated July 2013, and based on CDC guidelines, indicated all health care settings in Minnesota should perform an initial facility TB risk assessment. A TB infection control program should include the following: written TB infection control procedures. HCW's education should focus on basic information about your health care setting's infection control plan (i.e., how to implement your early recognition, isolation, and referral procedure), especially any sections that employees are responsible for implementing. The guidelines also indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		

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0 680	Continued From page 14	0 680		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 680		

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0 680	Continued From page 15 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's undated, Emergency Preparedness plan was reviewed and lacked the following: - document risk assessment for an all-hazards approach and develop strategies for addressing facility and community-based risks (evacuation plans, staffing surges/shortages, back-up plans). - process to address subsistence needs for staff and patients. - policy and procedure for a system to track the location of on-duty staff and sheltered residents. - policy to address system of medical documentation that preserves resident information, protects confidentiality and secures availability of records. - policy to address use of volunteers, including the process/role for integration. On March 18, 2025, at 2:13 p.m., housing manager (HM)-B stated she was unaware of all the requirements for emergency preparedness. The licensee's Emergency Preparedness policy dated January 10, 2022, indicated the licensee references the Centers of Medicare and Medicaid (CMS) operations manual Appendix Z; MN Rules 4659.0100. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 680		

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0 680	Continued From page 16 (21) days	0 680		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with Minnesota State Fire Code in Minnesota Rules chapter 7511. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On March 18, 2025, from 10:00 a.m. to 11:00 a.m. the surveyor toured the facility with licensed assisted living director (LALD)-A. The following was observed. There was a fountain style firework in resident room 4 next to the recliner. LALD-A stated that they were not aware of it. LALD-A had staff remove the firework from resident room upon discovery.	0 775		

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0 775	Continued From page 17 The possession, manufacture, storage, sale, handling and use of fireworks are prohibited. TIME PERIOD FOR CORRECTION: Two (2) days	0 775		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that functioned	0 780		

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0 780	Continued From page 18 and were interconnected so that the actuation of one alarm caused 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 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On March 18, 2025, from 10:00 a.m. to 11:00 a.m., the surveyor toured the facility with licensed assisted living director (LALD)-A. The surveyor asked LALD-A to initiate a test of the smoke alarms throughout the facility. Upon testing, it was found that the smoke alarms in the facility were not interconnected, and only sounded locally when the individual smoke alarm was tested. All dwelling units required to have multiple smoke alarms are required to have interconnected alarms so activation of one alarm activates all alarms within the dwelling unit. TIME PERIOD FOR CORRECTION: Two (2) day.	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	0 790		

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0 790	Continued From page 19 in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation 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: On March 18, 2025, from 10:00 a.m. to 11:00 a.m., the surveyor toured the facility with licensed assisted living director (LALD)-A. The portable fire extinguishers throughout the facility lacked records to show the required annual certification was completed. The portable fire extinguishers throughout the facility lacked records to show monthly visual inspections were complete.	0 790		

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0 790	Continued From page 20 Documentation is required to demonstrate fire extinguishers have been inspected by facility personnel monthly, and annually replaced with a new extinguisher or serviced annually by a certified technician. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 800		

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0 800	Continued From page 21 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On March 18, 2025, from 10:00 a.m. to 11:00 a.m., the surveyor toured the facility with licensed assisted living director (LALD)-A. The following was observed. EGRESS WINDOWS: The egress window in resident room had a broken handle and LALD-A could not open the window. The egress window in resident room 2 was difficult for LALD-A to open. Egress windows shall be maintained in an operational condition at all times. GENERAL MAINTENANCE: In the lower level by the patio door there was drywall tape that was falling off and hanging from the ceiling. There was a hole in the wall approximately 4 inches in diameter next to the outside of resident room 4's door. There was a missing door stop trim from the strike side of resident room 4's door. There was a hole in the wall in resident room 3 to the left of the bed that was approximately 8 inches wide and 16 inches tall. The door leading from the facility into the attached garage was missing the door handle and latch assembly.	0 800		

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0 800	Continued From page 22 TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	0 810		

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0 810	Continued From page 23 This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training. 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 or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On March 18, 2025, licensed assisted living director (LALD)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "Fire Safety", dated January 10, 2022, failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The provided FSEP was from a third-party provider and had not been updated to the specific facility.	0 810		

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0 810	Continued From page 24 The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. LALD-A lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. LALD-A stated that staff training is done through Educare and not on the facilities FSEP. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or	01910		

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01910	Continued From page 25 medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of medication including the medication's prescription number (Rx), as applicable, and to whom the medications were given for one of one discharged resident (R1). In addition, the licensee failed to dispose of discontinued or expired medication according to state and federal regulations for disposition of medications and controlled substances. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents).	01910		

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	35020	A. BUILDING: _____ B. WING _____	03/18/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01910	Continued From page 26 The findings include: MEDICATION DISPOSITION FOR DISCHARGED FILE R1 started receiving services May 31, 2024, with a diagnosis of fetal alcohol syndrome and cerebral stroke, and was discharged to another facility on February 14, 2025. R1's service plan dated February 7, 2025, indicated R1 received assistance with medication management. R1's progress notes dated February 17, 2025, indicated R1 was discharged to another facility with all prescribed medications. The note indicated the nurse from the new facility reviewed medications, discharge paperwork and medication list. R1's record included a document labeled current medication at discharge and was dated February 14, 2025. The document included the name of the medication, dosage, route, frequency, and Rx number. The document included a column labeled quantity sent that was left blank on the document. On March 17, 2025, at 1:00 p.m., registered nurse (RN)-D stated she was unaware of the requirement to include the quantity of medication. DISPOSAL OF DISCONTINUED OR EXPIRED MEDICATION On March 18, 2025, at 10:20 a.m., licensed assisted living director (LALD)-A unlocked a door	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35020	A. BUILDING: _____ B. WING _____	03/18/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01910	Continued From page 27 under the stairs to the lower level. The storage contained a cabinet with five shelves filled with clear plastic bins of discontinued/expired prescription medication bottles filled with medication. LALD-A stated that the prescription medication bottles contained expired medications that they have not disposed of yet. The plastic bins contained the following prescription bottles: - Naproxen - expiration June 26, 2022, for R4 - diphenhydramine - expiration April 2023, and quetiapine - expiration September 2023, for R4. - Combivent Inhaler - expiration August 2022, for R2 - Hydroxyzine 25 milligrams (mg) - expiration April 11, 2023, for R4 - Oxycodone 5 mg - expiration December 13, 2024, for R1 - Nicotine lozenges (5 boxes) - expiration April 30, 2024, for R4 - ibuprofen - expiration September 15, 2022, for R3 - Naproxen 500 mg - expiration April 30, 2024, for R4 - benzotropine 1 mg - expiration March 6, 2024 for R4 The licensee's Disposition and Disposal of Medications policy dated January 10, 2022, indicated discontinued medication will be disposed of according to the policy. Upon disposition the licensee will document the following information in the clinical record. a. Name, strength and prescription number of medication b. Quantity c. Method of disposition or to whom the medication was given. d. Date of disposition	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35020	A. BUILDING: _____ B. WING _____	03/18/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01910	Continued From page 28 e. Name/signature of staff or other individuals involved in disposition No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		

Minnesota Department of Health
Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
6512014500

Type: Full
Date: *03/18/25*
Time: 11:30:00
Report: 1047251071

Food and Beverage Establishment Inspection Report

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

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

License Categories:

Expires on: / /

Operator:

Phone #: 9522425411
ID #:

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

The following orders were issued during this inspection.

2-300 Personal Cleanliness

2-301.14B-G ***** Priority 1 *****

MN Rule 4626.0075B-G Food employees must wash their hands after: using the toilet; coughing or sneezing; using a handkerchief or disposable tissue; using tobacco; eating or drinking; handling soiled equipment or utensils; caring for or handling service animals or fish in an aquarium, molluscan shellfish or crustacea in a display tank; as frequently as necessary during food preparation to remove soil, contamination, and to prevent cross-contamination when changing food preparation tasks; when switching between working with raw food and working with RTE food; before donning gloves for working with food; and touching bare human body parts other than clean hands and clean exposed portions of arms.

EMPLOYEE OBSERVED HANDLING RAW CHICKEN AND CHANGING GLOVES BEFORE GRABBING MAYO, BUT THEY DID NOT WASH THEIR HANDS. EMPLOYEE WASHED HANDS AT REQUEST OF INSPECTOR.

Comply By: 03/18/25

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 EGGS LOCATED ABOVE RTE MILK AND VEGGIES. CORRECTED IN SITE- RELOCATED TO LOWER SHELF

Comply By: 03/18/25

4-300 Equipment Numbers and Capacities

4-302.14 ***** Priority 2 *****

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

FACILITY IS CURRENTLY USING SANITIZER TO WASH DISHES DUE TO INOPERABLE DISHWASHER. CHLORINE TEST STRIPS PROVIDED AT TIME OF INSPECTION. FACILITY WILL NEED TO ACQUIRE MORE TO CONTINUE TO TEST BLEACH CONCENTRATION FOR EQUIPMENT SANITIZING

Comply By: 03/18/25

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

NO STATE CERTIFIED FOOD PROTECTION MANAGER FOR THE ESTABLISHMENT

Comply By: 04/18/25

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

DISHWASHER IS NOT FUNCTIONAL. FACILITY STATED THEY WILL BE GETTING A NEW ONE.

SOME CABINETS ARE IN DISREPAIR. RECONNECT CABINET DOORS AND CABINET HANDLES THAT ARE FALLING OFF.

Comply By: 03/18/25

4-600 Cleaning Equipment and Utensils

4-601.11C

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

SYRUP SPILL LOCATED IN LOWER CABINET

Comply By: 03/18/25

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: Refrigeration- cheese
Violation Issued: No

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

Inspection conducted with operator and reviewed with MDH Nurse Evaluator T. Fearon.

The establishment has a residential kitchen and serves food that is prepared that day. The kitchen has wood cabinets, wood floor, tiled & painted walls, and painted textured ceiling.

Type: Full
Date: *03/18/25*
Time: 11:30:00
Report: 1047251071
Open Arms Llc

Food and Beverage Establishment Inspection Report

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

A residential dish machine is located in the kitchen. The dishmachine is not currently operational and facility is using sink & additional basin for wash/rinse/sanitize procedures. Facility is in the process of acquiring a new dishwasher.

Discussed hand washing, ware washing, staff illness policy, temperature control, final cook temperature, cleaning/sanitizing procedures, serving highly susceptible populations, and food handling procedures

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1047251071 of 03/18/25.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Fathiya Hassan
Operator

Signed:_____
Holly Sievers
Public Health Sanitarian 2
Metro Office
6512015946
Holly.Sievers@state.mn.us