DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

July 7, 2023

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

RE: Project Number(s) SL37990015

Dear Licensee:

On June 29, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the March 7, 2023, 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,

Jill Hagen

Jill Hagen, Supervisor
State Rapid Response Team
Email: jill.hagen@state.mn.us
Telephone: 218-332-5141 Fax: 651-215-6894

PMB

Electronically Delivered

April 13, 2023

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

RE: Project Number(s) SL37990015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial evaluation on March 7, 2023, for the purpose assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

STATE LICENSING ORDERS
The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care 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 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 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.

In accordance with Minn. Stat. § 144G.20, Subd. 4(a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572. Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4(a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

St - 0 - 0495 - 144g.41 Subd. 1 (14) - Minimum Requirements - $3,000.00
St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00

The total amount you are assessed is $6,000.00. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction 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 residents/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 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 the Department of Health within 15 calendar days of the correction order receipt date.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

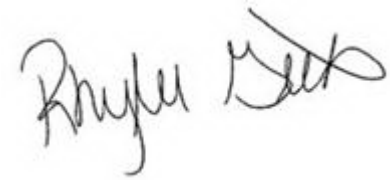
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

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.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,



Rhylee Gilb, Supervisor
State Rapid Response Team
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone: 218-232-8285 Fax: 651-215-6894

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37990	A. BUILDING: _____ B. WING _____	03/07/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER 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: ***Revised* #SL37990015 On March 6 and 7, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey and investigation, there was one resident receiving services under the provider's Provisional Assisted Living Facility license. The immediacy was removed on March 8, 2023, for tags 0495 and 1290. The following correction orders are issued that were not issued at the time of immediate correction orders, tag 0110, 0470, 0480, 0680, 0820, 1790, and 1940.	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 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 144G.31 subd. 1, 2, and 3.	
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports.? This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's 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). Findings include: On March 6, 2023, at 9:30 a.m., during entrance conference, owner (OW)-C identified licensed assisted living director (LALD)-D as the LALD director of record for the licensee. Review of the Board of Executives for Long-Term Services and Support (BELTSS) website on March 6, 2023, at 9:35 a.m.,, indicated LALD-D held a current assisted living director license. The BELTSS website did not indicate LALD-D as the Director of Record for the licensee. On March 6, 2023, at 9:40 a.m., OW-C verified the BELTSS website and acknowledged LALD-D	0 110		

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0 110	Continued From page 2 was not listed as the Director of Record for the licensee On March 7, 2023, at 10:15 a.m. LALD-D identified herself as the director of record for the licensee. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for 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	0 470		

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0 470	Continued From page 3 (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 ensure the 24-hour staffing schedule was posted in a central location for residents, staff and visitors to review as required. This had the potential to affect all residents and staff. 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). Findings include: On March 6, 2023, at 10:30 a.m., during a tour of the facility, the surveyor observed the licensee lacked posting of a daily staffing schedule. During an interview on March 6, 2023, at 10:30 a.m., owner (OW)-C stated the staff schedule was not posted. 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:	0 480		

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0 480	Continued From page 4 (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to comply with Minnesota Food Code, Chapter 4626. This had the potential to affect all of the residents residing at 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 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). Findings include: Please refer to the additional documentation included in the Food and Beverage Establishment Inspection Reports dated March 6, 2023. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	0 480		
0 495 SS=I	144G.41 Subd. 1 (14) Minimum Requirements (14) provide staff access to an on-call registered nurse 24 hours per day, seven days per week This MN Requirement is not met as evidenced by: Based on interview and record review, the	0 495		

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0 495	Continued From page 5 licensee failed to ensure staff had access to the registered nurse (RN) at any time due to the only licensee RN employed by the licensee having another full-time job at a home care agency. This affected all residents and unlicensed staff. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at 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). Findings include: R1's medical record indicated R1's diagnoses included paranoid schizophrenia, suicidal ideation, depression and anxiety. RN-B personnel file indicated RN-B's date of hire was December 20, 2022. During an interview on March 6, 2023, at 2:19 p.m. owner (OW)-C stated it would be hard to have RN-B come to the licensee during survey because she works Tuesday, Wednesday and Thursday [at her other job]. During an interview on March 7, 2023, at 9:34 a.m., RN-B stated she worked Monday through Thursday from nine in the morning to five at night at a home care agency. RN-B further stated in an emergency either licensed practical nurse (LPN)-E or OW-C, who is an unlicensed personnel, can assist with an emergency with the resident.	0 495		

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0 495	Continued From page 6 During an interview on March 7, 2023, at 10:15 a.m., OW-C was notified of the immediate concern. OW-C stated RN-B is able to be reached by phone. However OW-C provided acknowledgement of RN-B not being able to answer the phone if RN-B is working with another resident at her other employment. RN-B was not present during the two days of survey. The licensee's policy titled Availability of an RN for Staff dated August 1, 2021, directed the RN must be readily available either in person, by telephone or by other means to the staff at times when the staff is providing services. The on-call licensed health professional shall respond and provide consultation to the staff in a timely manner based on the communicated information. TIME PERIOD FOR CORRECTION: IMMEDIATE The immediacy was removed on March 8, 2023. The licensee sent in a plan of correction and indicated the LALD would serve as an alternate RN.	0 495		
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;	0 680		

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0 680	Continued From page 7 (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 develop a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all of the licensee's 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 the residents). Findings include: On March 7, 2023, at 10:35 a.m., the licensee's EPP was reviewed with owner (OW)-C. During the review OW-C verified the following policies and procedures were missing from the EPP.	0 680		

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0 680	Continued From page 8 The licensee's EPP did not include the following content: - a description of the population served by the licensee to identify at risk populations - process for cooperation and collaboration with state and local, tribal, regional, State and Federal EP officials/organizations - policy and procedures to address: system of medical documentation that preserves resident information, protects confidentiality and secures/maintains availability of records - policy and procedure that addresses use of volunteers, including the process/role for integration - development of a communication plan that included: - names and contact information of staff, entities providing services, residents' physicians and other facilities, volunteers. - emergency officials contact information - primary and alternate means of communicating with facility staff, federal, state, tribal, regional and local emergency management agencies -method for sharing information and medical documentation for residents under the licensee's care to maintain continuity of care - sharing information on occupancy needs The licensee's policy titled Emergency Preparedness Plan- Appendix Z compliance dated August 1, 2021, directed the licensee's EPP will be aligned with the Centers for Medicare and Medicaid Services State Operations Manual Appendix Z. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		

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0 820	Continued From page 9	0 820		
0 820 SS=E	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 required egress windows in the upstairs sleeping rooms. This deficient condition had the ability to affect a portion of the staff and residents. This practice resulted in a level two distinct hazard 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). Findings include:	0 820		

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0 820	Continued From page 10 On facility tour with (Owner)-C on March 8, 2023, at approximately 10:30 a.m., it was observed that the two unoccupied sleeping rooms on the upper level had windows that did not meet the egress requirements. The windows measured 21.5 inches by 29.25 inches when fully opened for a total of 628.875 square inches. Windows used for egress purposes in sleeping rooms must not have less than 20 inches of height and 20 inches of width of openable area and not less than 648 total square inches in openable area. All windows must meet these requirements prior to a resident occupying the room. These deficient conditions were visually verified by Owner-C accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 820		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits.	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37990	A. BUILDING: _____ B. WING _____	03/07/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01290	Continued From page 11	01290		

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to complete a background study prior to staff providing care services, for one of one licensed practical nurse, (LPN)-E, of employee records reviewed. This had potential to affect all residents, staff and visitors.

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 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).

Findings include:

R1's medical record indicated R1's diagnoses included paranoid schizophrenia, suicidal ideation, depression and anxiety.

R1's progress notes dated January 26, 27, and 30, 2023, were signed by LPN-E. LPN-E also documented progress notes on February 16, 2023, and March 2, 2023.

On March 6, 2023, owner (OW)-C provided a completed employee list and LPN-E was not listed on the employee list.

On March 7, 2023, at 10:10 a.m., LPN-E's employee record was reviewed. The licensee was unable to provide a cleared background study for LPN-E.

A search of the Minnesota Department of Human

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37990	A. BUILDING: _____ B. WING _____	03/07/2023

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01290	Continued From page 12 Services background study website conducted on March 7, 2023, indicated on January 9, 2023, LPN-E had an affiliation date. On January 24, 2023, LPN-E had a separation date from licensee. The website confirmed LPN-E failed to have a completed cleared background study. The licensee was notified of the immediate correction order on March 7, 2023, at 10:15 a.m. During interview on March 7, 2023, at 10:15 a.m. OW-C stated he forgot to add LPN-E to the employee list. OW-C then stated he did not know why LPN-E did not have a cleared background. OW-C stated LPN-E had only been working with the facility for a few weeks. OW-C verified LPN-E's signature on R1's progress notes. The licensee's policy titled Background Studies dated August 1, 2021, directed no employee may provide direct services and have independent direct contact with any residents until acceptable result of the background study have been received. The policy further directed copies of the completed background studies shall be kept in individual employee records. TIME PERIOD FOR CORRECTION: Immediate. The immediacy was removed on March 3, 2023. The licensee contacted the background study unit and the date of LPN-E's clearance letter was March 8, 2023.	01290		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed	01790		

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01790	Continued From page 13	01790		

nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days;
(3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and
(4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled.
(b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if:
(1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and
(2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address:
(i) the type of container or containers to be used for the medications appropriate to the provider's medication system;
(ii) how the container or containers must be labeled;
(iii) written information about the medications to be provided;
(iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of

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01790	Continued From page 14 medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) developed training and competencies for unlicensed personnel (ULP) who provided medications to residents for unplanned time away from home when the licensed nurse was not available for one of one employee (ULP-A) with record reviewed. 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). Findings include: On March 6, 2023, at 11:21 a.m. ULP-A provided	01790		

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01790	Continued From page 15 medication management services to R1. Review of ULP-A personnel file indicated ULP-A's date of hire was January 2, 2023. ULP-A's record lacked documentation of training and competency by the RN for providing medications to residents for unplanned time away when the RN is not available. On March 6, 2023, at 11:45 a.m., owner (OW)-C verified ULP-A's record lacked documentation of training and competency by a RN for medication set-up by the ULP during a residents unplanned time away. The licensee's Medication Management- Planned and Unplanned Time Away policy, dated August 1, 2021, directed for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or properly trained and competency tested unlicensed personnel may give the resident or resident's representative medications in amounts and dosages needed for the length of the anticipated absence. TIME PERIOD FOR CORRECTION: Seven (7) days.	01790		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy	01940		

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01940	Continued From page 16 management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview, observation and record review, the licensee failed to develop and implement a treatment or therapy management plan to include the required content for one of one resident (R1) with records reviewed. 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).	01940		

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01940	Continued From page 17 Findings include: R1's record lacked evidence of an individualized treatment or therapy management plan for blood sugar checks. R1's physician orders dated February 22, 2023, directed staff to check R1's blood sugar once a day in the morning. R1's progress note dated March 2, 2023, directed staff to check R1's blood sugar once daily in the mornings. During an interview on March 7, 2023, at 10:00 a.m., registered nurse (RN)-B stated R1's medical record was not updated to include blood sugar checks. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		

Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul
6512014500

Type: Full
Date: *03/06/23*
Time: 12:00:49
Report: 1029231035

Food and Beverage Establishment Inspection Report

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

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

License Categories:

Expires on: 12/31/23

Operator:

Phone #:
ID #:

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

The following orders were issued during this inspection.

3-500C Microbial Control: date marking
3-501.17B ***** Priority 2 *****

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

Opened package of thawing hotdogs not date marked. Instructed Jowhara and Abdirizak to make sure items are date marked using the opening day as day 1 and continue to count each subsequent day in refrigeration when not in freezer.

Comply By: 03/06/23

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.

Maximum registering thermometer or temperature stickers not present to verify the highest sanitizing temperature reached in the dishwasher. Instructed Jowhara and Abdirizak to obtain something to measure max temp.

Comply By: 03/10/23

7-100 Toxic Labeling

7-102.11 ***** Priority 2 *****

MN Rule 4626.1595 Clearly label all working containers used for storing poisonous or toxic materials from bulk supplies such as sanitizers and cleaners, with the common name of the product.

Spray bottle with chemical cleaner not labeled. Insructed Jowhara and Abdirizak to label all chemical containers.

Comply By: 03/06/23

Food and Equipment Temperatures

Process/Item: almond milk
Temperature: 37 Degrees Fahrenheit - Location: refrigerator
Violation Issued: No

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

Conducted inspection of food services area at Open Heart Residence with Jowhara Mohamed, ULBA, Abdirizak Osman, Owner/Operator/CFPM. All issues were discussed with Jowhara and Abdirizak during and after the inspection. Employee illness reporting and exclusion procedures, vomit/fecal matter cleanup, and foodborne illness pathogens were also discussed in addition to general food safety practices regarding highly susceptible populations. Establishment serves one 64-year-old client.

Kitchen area has vinyl tile flooring, painted wood drawers and cabinetry, wood trim about 4' up the wall, smooth painted walls and ceiling, and unfinished wood countertops. Some of the interiors of the drawers were also unfinished. There was a gap at the sink counter interface and at the counter wood trim juncture. I informed Jowhara and Abdirizak that the gaps would need to sealed and the unfinished wood surfaces would need to be finished or sealed with a material that is smooth, durable, easily cleanable, and non-absorbent. There is a possibility that the countertops are a tight-grained hard wood. I informed Abdirizak that the countertops would need to be verified as a non-absorbent surface, such as a hard maple or an equivalently hard, close-grained wood, or they would require a finished non-absorbent material on the surface.

All identified issues communicated to lead HRD survey and Special Investigator, Brandon Martfeld, RN, BSN.

Food and Beverage Establishment Inspection Report

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 1029231035 of 03/06/23.

Certified Food Protection Manager: Abdirizak Sharif Osman

Certification Number: FM108751 Expires: 07/22/24

Signed: _____

Abdirizak Osman
Owner/Operator

Signed: _____

Trevor McCliment
Public Health Sanitarian
Metro District Office
651-201-3957
trevor.mccliment@state.mn.us

Report #: 1029231035

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul

No. of RF/PHI Categories Out	1	Date	03/06/23
No. of Repeat RF/PHI Categories Out	0	Time In	12:00:49
Legal Authority MN Rules Chapter 4626		Time Out	

	Address	City/State	Zip Code	Telephone
Open Heart Residence	4945 Drew Avenue South	Minneapolis, MN	55410	

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0041104		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

	Compliance Status		COS	R
	Supervision			
1	(IN) OUT	PIC knowledgeable; duties & oversight		
2	(IN) OUT N/A	Certified food protection manager, duties		
	Employee Health			
3	(IN) OUT	Mgmt/Staff;knowledge,responsibilities&reporting		
4	(IN) OUT	Proper use of reporting, restriction & exclusion		
5	(IN) OUT	Procedures for responding to vomiting & diarrheal events		
	Good Hygenic Practices			
6	IN OUT (N/O)	Proper eating, tasting, drinking, or tobacco use		
7	(IN) OUT N/O	No discharge from eyes, nose, & mouth		
	Preventing Contamination by Hands			
8	IN OUT (N/O)	Hands clean & properly washed		
9	IN OUT N/A (N/O)	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	(IN) OUT	Adequate handwashing sinks supplied/accessible		
	Approved Source			
11	(IN) OUT	Food obtained from approved source		
12	IN OUT N/A (N/O)	Food received at proper temperature		
13	(IN) OUT	Food in good condition, safe, & unadulterated		
14	IN OUT (N/A) N/O	Required records available; shellstock tags, parasite destruction		
	Protection from Contamination			
15	(IN) OUT N/A N/O	Food separated and protected		
16	(IN) OUT N/A	Food contact surfaces: cleaned & sanitized		
17	(IN) OUT	Proper disposition of returned, previously served, reconditioned, & unsafe food		

	Compliance Status		COS	R
	Time/Temperature Control for Safety			
18	IN OUT N/A (N/O)	Proper cooking time & temperature		
19	IN OUT N/A (N/O)	Proper reheating procedures for hot holding		
20	IN OUT N/A (N/O)	Proper cooling time & temperature		
21	IN OUT N/A (N/O)	Proper hot holding temperatures		
22	(IN) OUT N/A	Proper cold holding temperatures		
23	IN (OUT) N/A N/O	Proper date marking & disposition		
24	IN OUT (N/A) N/O	Time as a public health control: procedures & records		
	Consumer Advisory			
25	IN OUT (N/A)	Consumer advisory provided for raw/undercooked food		
	Highly Susceptible Populations			
26	(IN) OUT N/A	Pasteurized foods used; prohibited foods not offered		
	Food and Color Additives and Toxic Substances			
27	IN OUT (N/A)	Food additives: approved & properly used		
28	IN (OUT)	Toxic substances properly identified, stored, & used		
	Conformance with Approved Procedures			
29	IN OUT (N/A)	Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
		Safe Food and Water		
30	IN OUT (N/A)	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT (N/A)	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A (N/O)	Plant food properly cooked for hot holding		
35	(IN) OUT N/A N/O	Approved thawing methods used		
36		Thermometers provided & accurate		
		Food Identification		
37		Food properly labled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
		Proper Use of Utensils		
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
		Utensil Equipment and Vending		
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48	X	Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
		Physical Facilities		
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) — **Date:** 03/06/23

Inspector (Signature)