Electronically Delivered

November 15, 2023

Licensee
Open Arms Senior Living
4414 Martin Road
Duluth, MN 55803

RE: Project Number(s) SL38681015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license with dementia care.** 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 survey on November 8, 2023, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

The Department of Health 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. The Department of Health documents state 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 . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

DOCUMENTATION OF ACTION TO COMPLY
Per 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 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 correction 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
HRD 3A, 3rd Floor
P.O. Box 64900
625 Robert Street North
St. Paul, MN 55164

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

If you have any questions, please contact me.

Sincerely,

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 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
	38681	A. BUILDING: _____ B. WING _____	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS SENIOR LIVING	4414 MARTIN ROAD DULUTH, MN 55803

(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(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: SL38681015-0 On November 6, 2023, through November 8, 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, there were 23 active residents whom were receiving services under the Assisted Living with Dementia 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 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.	
0 680 SS=C	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following	0 680		

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0 680	Continued From page 1 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 observation, interview, and record review, the licensee failed to prominently post an emergency disaster plan. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 680		

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0 680	Continued From page 2 The findings include: On November 6, 2023, at 11:50 a.m., clinical nurse supervisor (CNS)-B and the surveyor toured the main commons area and hallways and observed the facility did not have an emergency disaster plan posted prominently. On November 6, 2023, at 12:00 p.m., the surveyor requested CNS-B point out where the emergency disaster plan would be posted. CNS-B stated the emergency plan binder was locked in a cupboard in the nurse's station. CNS-B took the surveyor to the locked cupboard and was unable to locate keys to open the cupboard to provide the emergency plan binder at that time. On November 6, 2023, at 12:10 p.m., CNS-B confirmed the emergency disaster plan was not posted and was unaware of the requirement. The licensee's Disaster Planning and Emergency Preparedness policy dated October 17, 2022, did not include information about posting an emergency disaster plan prominently. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 800 SS=E	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	0 800		

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0 800	Continued From page 3 good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to affect a limited number of residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On a facility tour on November 6, 2023, at 12:30 p.m., with licensed assisted living director (LALD)-A, the surveyor made the following observations of facility hazards and disrepair: A door closer was removed from the fire-resistant rated door of the mechanical room. Door closers on fire resistant rated doors are required to be maintained to close and latch automatically as designed and installed at the time of construction approval.	0 800		

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0 800	Continued From page 4 A compliant guardrail on the open side of the stairway leading to the mechanical room mezzanine was not provided. Open sides of stairways for mechanical mezzanines are required to be provided with guardrails that have openings not more than 21" and the guardrail is required to be 42" high. The exhaust fan in the salon was not operating. Exhaust fans are required to be maintained in an operational condition in order to direct exhaust air to the exterior of the building. Three ceiling tiles were missing in the commercial kitchen above the walk-in cooler door. Ceiling tiles are required to be maintained in position in buildings provided with fire sprinklers as designed and installed at the time of construction approval. On November 6, 2023, at 12:30 p.m., LALD-A verified these deficient conditions while accompanying on the tour. 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) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and	0 810		

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0 810	Continued From page 5 (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to maintain the facility's fire safety and evacuation plan with required elements. 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	0 810		

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0 810	Continued From page 6 the residents). The findings include: On November 6, 2023, at 12:00 p.m., licensed assisted living director (LALD)-A, provided documents on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the licensee failed to include detailed fire protection procedures for resident instruction necessary in the event of a fire or similar emergency for this facility. Record review of the available documentation indicated the licensee failed to include unique and unusual needs for individual resident movement or evacuation during a fire or similar emergency. Documentation of unique and unusual needs for evacuation of each resident in the facility is required to be kept with the fire safety and evacuation plan for reference in the event of a fire or similar emergency. Record review of the available documentation indicated employees did not receive training based on the fire safety and evacuation plan for the specific facility. Training of employees is required at hire and twice per year thereafter on the facility fire safety and evacuation plan and procedures of this facility. Employee training based on the facility fire safety and evacuation plan is required to be completed and documented separately from evacuation drills. On November 6, 2023, at 12:00 p.m., LALD-A, verified the deficiencies of the documents during the interview.	0 810		

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0 810	Continued From page 7 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure service plans were updated for one of three residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01640		

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01640	Continued From page 8 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included left sided stroke and Parkinson's disease. R1's service plan dated April 13, 2023, indicated R1 received assistance with medication administration, bathing, escorts, transfers, ambulation, bed mobility, repositioning, eating assist, dressing, grooming, oral care, treatment to include compression stockings (TEDs), safety checks, toileting, housekeeping and laundry. On November 6, 2023, at 1:13 p.m., the surveyor observed unlicensed personnel (ULP)-C administer R1's afternoon medications and noted an oxygen concentrator (medical device that delivers purified oxygen to people with low oxygen levels) located next to R1's bed. R1's prescriber orders dated May 16, 2023, included orders for oxygen supplement, two to four liters per minute (LPM) via nasal canulla as needed (PRN). On November 7, 2023, at 8:50 a.m., ULP-C stated oxygen wasn't in the electronic treatment administration record (ETAR) as a task, however, staff assisted R1 with the oxygen "every night and as needed". Additionally, the ETAR included application and removal of TEDs daily. The surveyor asked ULP-C if staff were assisting R1 with TEDs. ULP-C stated, "he hasn't worn them in	01640		

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01640	Continued From page 9 the six months I've been here". R1's service plan dated April 13, 2023, did not include oxygen assistance provided, however, did include TEDs service not provided. On November 8, 2023, at 9:08 a.m., clinical nurse supervisor (CNS)-B acknowledged R1's service plan had not been revised or updated and stated, "that would be a communication and assessment thing". The licensee's Service Plan Modifications policy dated October 17, 2022, noted when a resident receives assisted living services and a change occurs, the service plan must be amended in writing and signed by the resident or the resident's designated representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes:	01650		

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01650	Continued From page 10 (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included the required content for three of three residents (R2, R1, R6). 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: R2 R2's diagnoses included Alzheimer's and diabetes mellitus type II.	01650		

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01650	Continued From page 11 On November 6, 2023, at 1:07 p.m., the surveyor observed unlicensed personnel (ULP)-C administer R2's afternoon medications. R1 R1's diagnoses included left sided stroke and Parkinson's disease. On November 6, 2023, at 1:13 p.m., the surveyor observed ULP-C administer R1's afternoon medications. R6 R6's diagnoses included Parkinson's disease, anxiety, depression, hypothyroidism (low thyroid level), and hypotension (high blood pressure). On November 8, 2023, at 11:21 p.m., the surveyor observed ULP-C administer R6's scheduled medications. R2, R1 and R6's Service Plans dated May 17, 2023, April 13, 2023, and March 22, 2023, respectively, lacked the following required content: -the schedule and methods of monitoring assessments of the resident; -the schedule and methods of monitoring staff providing services; and -a contingency plan that includes the action to be taken if the scheduled service cannot be provided. On November 7, 2023, at 9:13 a.m., clinical nurse supervisor (CNS)-B reviewed the licensee's service plan template and stated the resident service plans did not include the required content noted above and was not aware of the requirement.	01650		

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01650	Continued From page 12 The licensee's Service Plan policy dated October 17, 2022, indicated the written service plan must include: -the schedule and methods of monitoring assessments of the resident; -the schedule and methods of monitoring staff providing services; and a contingency plan that include the action to be taken if the scheduled service cannot be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. 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) included resident-specific instructions for unlicensed staff to follow when administering medications for one of three residents (R1).	01750		

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01750	Continued From page 13 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's electronic medication administration record (EMAR) lacked specific, written instructions, regarding the administration of crushed medications. R1's diagnoses included left sided stroke and Parkinson's disease. R1's service plan dated April 13, 2023, indicated R1 received assistance with medication administration. R1's EMAR, dated October 2023, included: aldactone 25 milligrams (mg) for edema, carbidopa-levodopa 10/100 mg for Parkinson's disease, aspirin 81 mg for congestive heart failure (CHF), clopidogrel 75 mg for CHF, furosemide 40 mg for edema, losartan potassium 25 mg for hypertension, miralax 17 grams (GM) for constipation, multivitamin for vitamin supplement, omega-3 1000 mg for vitamin supplement, pantoprazole sodium 40 mg for heartburn, sertraline 25 mg for depression, torsemide 20 mg for edema, and acetaminophen 1000 mg for pain. On November 6, 2023, at 1:13 p.m., the surveyor	01750		

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01750	Continued From page 14 observed unlicensed personnel (ULP)-C administer R1's afternoon medications. ULP-C opened the locked medication cart and popped the pill from a bubble pack (a foil backed, cardboard medication organizer) into a paper medication cup. ULP-C verified the medication in the EMAR. ULP-C poured the pill into a small clear baggie from the paper medication cup and crushed the pill with a hand held medical device designed to crush medications. ULP-C poured the crushed medication from the baggie into a tablespoon of pudding and stirred. ULP-C administered the medications to R1 and documented in the EMAR. The surveyor asked ULP-C to show the surveyor where in the EMAR it provided instructions to crush R1's medications. ULP-C reviewed the EMAR with the surveyor and was unable to find instructions to crush R1's medications. ULP-C stated, "it should be here, we know we crush them because he is a choking risk". On November 8, 2023, at 9:40 a.m., clinical nurse supervisor (CNS)-B confirmed there were no specific instructions for R1's medications to be crushed and stated, "there is nothing in there (referencing crush instructions in EMAR). It could have been missed when his medications were started, when we first opened". The licensee's Medication and Treatment - Administration and Delegation policy dated October 30, 2022, indicated the RN must specify, in writing, specific instructions for the resident and documented those instructions in the resident's record when medication administration is delegated or assigned to unlicensed personnel. No further information was provided.	01750		

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01750	Continued From page 15 TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Surveyor: Barnhardt, Katherine Based on observation, interview, and record review, the licensee failed to ensure refrigerated medications were maintained at manufacturer recommended temperatures by failing to monitor and document medication refrigerator temperatures for one of one medication refrigerator. 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 November 8, 2023, at 10:42 a.m., licensed practical nurse (LPN)-D and the surveyor observed a medication refrigerator located in the nurses office. LPN-D verified the temperature 41 degrees Fahrenheit (F) digitally displayed on the	01880		

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01880	Continued From page 16 refrigerator. The surveyor and LPN-D reviewed temperature logs and noted the following dates missed temperature verification; October 1, 11, 12, 14, 15, 20, 21, 27, 29, 2023. The temperature log referenced only Celsius (C) temperature ranges and the refrigerator displayed Fahrenheit temperatures. The surveyor asked LPN-D how staff knew if the refrigerator was in the correct temperature range and LPN-D stated, "I'm not sure". Clinical nurse supervisor (CNS)-B reviewed the logs and stated she was also unsure of how staff were monitoring the medication refrigerator for the correct temperature range. Licensed assisted living director (LALD)-A stated, "they are using the wrong one". The medication refrigerator content included the following medications: -one unopened Novolog (rapid acting insulin) pen 100 units (u)/milliliters (ml) for R2; -ten unopened Novolog insulin pens 100 u/ml, one unopened Lantus Solostar (long-acting insulin) pen, and one unopened Ozempic injection pen 2 mg/3 ml (non-insulin injection used to treat diabetes) for R4; and -one unopened latanoprost (used to treat eye pressure) 0.05% eye drop for R9. The manufacturer's instructions for Novolog insulin pen dated March 2021, indicated to store unopened Novolog in the refrigerator at 36-46 degrees F and do not freeze. The manufacturer's instructions for Lantus insulin dated June 2022, indicated to store unused Lantus Solostar insulin pens in the refrigerator between 36-46 degrees F and do not freeze. Unused Lantus should be discarded 28 days after opened.	01880		

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01880	Continued From page 17 The manufacturer's instructions for Ozempic injection pen dated 2022, indicated to store unopened Ozempic in the refrigerator at 36-46 degrees F and do not freeze. The manufacturer's instructions for latanoprost eye drop dated August 2011, indicated to store unopened latanoprost in the refrigerator at 36-46 degrees F. The licensee's Medication Storage policy, dated October 30, 2022, indicated medication would be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01910 SS=D	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 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	01910		

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01910	Continued From page 18 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 the medications for one of one resident (R5) upon discharge. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R5 was admitted November 30, 2022, and discharged October 15, 2023. R5's Medication List dated May 23, 2023, indicated R5 received the following scheduled prescription medications: -acetaminophen (pain reliever) 500 milligram (mg) three times a day; -amlodipine (used to treat high blood pressure) 5 mg one tablet daily; -levothyroxine (used to treat hypothyroidism) 100 micrograms (mcg) one tablet daily; -lidocaine 4% patch (used to treat pain) apply one patch to right and left hip daily and remove at night;	01910		

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01910	Continued From page 19 -Miralax (used to treat constipation) 17 grams (gm) one scope daily; -oxybutynin (bladder relaxant) 10 mg one tablet daily; -pantoprazole (used to treat acid reflux) 20 mg one tablet every morning; -Senna (laxative) 8.6 mg two tables daily; -quetiapien fumarate (used to treat depression) 25 mg take ½ pill at bedtime; -aspirin 325 mg one tablet; -atorvastatin (used to treat high blood pressure) 40 mg one tablet daily; and -vitamin D3 (supplement) 25 micrograms (mcg) one tablet daily. R5's record did not include a disposition of medications to include medications 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. On November 7, 2023, at 3:30 p.m., clinical nurse supervisor (CNS)-B stated R5's record did not include documentation of the disposal of R5's medications and further stated she was unaware of the requirement. The licensee's Medication Disposal policy dated October 30, 2022, indicated upon disposition, the license must document in the resident record the disposition of the medication including the medication's name, strength, prescription numbers applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. No further information was provided.	01910		

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01910	Continued From page 20 TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
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 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:	01940		

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01940	Continued From page 21 Based on observation, interview, and record review, the licensee failed to develop an individual treatment management plan with all required content for one of one resident (R1) who received ordered treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on November 6, 2023, at 10:30 a.m., licensed assisted living director (LALD)-A confirmed the licensee provided treatment and therapy services to residents. R1's diagnoses included left sided stroke and Parkinson's disease. R1's service plan dated April 13, 2023, indicated R1 received assistance with medication administration, bathing, escorts, transfers, ambulation, bed mobility, repositioning, eating assist, dressing, grooming, oral care, treatment to include compression stockings (TEDs), safety checks, toileting, housekeeping and laundry. The service plan lacked to include oxygen treatments. On November 6, 2023, at 1:13 p.m., the surveyor observed unlicensed personnel (ULP)-C administer R1's afternoon medications and noted an oxygen concentrator (medical device that	01940		

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01940	Continued From page 22 delivers purified oxygen to people with low oxygen levels) located next to R1's bed. The surveyor asked ULP-C if R1 used the oxygen concentrator and ULP-C stated staff have assisted R1 with oxygen supplementation via nasal canulla every night. R1's prescriber orders dated May 16, 2023, included orders for oxygen supplement, two to four liters per minute (LPM) via nasal canulla as needed (PRN). R1's record lacked an Individualized Treatment and Therapy plan to include the following: - a statement of the type of services that will be provided; - documentation of specific resident instructions relating to the treatment or therapy administration; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; and - any resident-specific requirements related to documentation of treatment and therapy was received, verification all treatment and therapy was administered as prescribed, and monitoring occurred to prevent possible complications or adverse reactions. On November 7, 2023, at 3:13 p.m., clinical nurse supervisor (CNS)-B confirmed R1 lacked an Individualized Treatment and Therapy Plan to include the above noted requirements. The licensee's Treatment and Therapy Management Plan policy dated October 30, 2022, indicated the licensee would develop and maintain a current individualized treatment and therapy management record for each resident receiving treatments and would include all items noted above.	01940		

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01940	Continued From page 23 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee lacked proper documentation of oxygen treatment effectiveness for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	01960		

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01960	Continued From page 24 R1's diagnoses included left sided stroke and Parkinson's disease. R1's service plan dated April 13, 2023, indicated R1 received assistance with medication administration, bathing, escorts, transfers, ambulation, bed mobility, repositioning, eating assist, dressing, grooming, oral care, treatment to include compression stockings (TEDs), safety checks, toileting, housekeeping and laundry. The service plan lacked oxygen treatment. On November 6, 2023, at 1:13 p.m., the surveyor observed unlicensed personnel (ULP)-C administer R1's afternoon medications and noted an oxygen concentrator (medical device that delivers purified oxygen to people with low oxygen levels) located next to R1's bed. The surveyor asked ULP-C if R1 used the oxygen concentrator and ULP-C stated staff have assisted R1 with oxygen supplementation via nasal canulla every night. R1's prescriber orders dated May 16, 2023, included orders for oxygen supplement, two to four liters per minute (LPM) via nasal canulla as needed (PRN). On November 7, 2023, at 3:13 p.m., clinical nurse supervisor (CNS)-B confirmed R1's record lacked a means for staff to document the task completion and effectiveness of oxygen treatment as prescribed by the physician. The licensee's Treatment and Therapy Management Plan policy dated October 30, 2022, indicated the licensee would maintain a treatment and therapy management record for each resident which would include verification all	01960		

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01960	Continued From page 25 treatments and therapies were administered as prescribed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
02110 SS=C	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only;	02110		

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OPEN ARMS SENIOR LIVING	4414 MARTIN ROAD DULUTH, MN 55803

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02110	Continued From page 26 (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the required dementia care policies and procedures were provided to each resident and/or the resident's legal and designated representatives for three of three residents (R1, R2, R6). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The facility held an Assisted Living with Dementia Care license. R1 R1 was admitted November 30, 2022. R1's diagnoses included transient ischemic attack (mini stroke) and Parkinson's disease. R2 R2 was admitted May 5, 2023.	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38681	A. BUILDING: _____ B. WING _____	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS SENIOR LIVING	4414 MARTIN ROAD DULUTH, MN 55803

(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
02110	Continued From page 27 R2's diagnoses included Alzheimer's disease. R6 R6 was admitted March 22, 2023. R6's diagnoses included Parkinson's disease, depression, and anxiety. R1, R2, and R6's records did not include evidence or documentation the resident or resident's representative had received the policies and procedures related to dementia care as required. On November 7, 2023, at 11:30 a.m., licensed assisted living director (LALD)-A stated the residents and/or residents' representatives were verbally told about the dementia care policies at the time of admission; however, did not have a signed acknowledgement the dementia care policies were offered or provided. The licensee's Assisted Living with Dementia Care Additional Required policies dated October 17, 2022, indicated the policies and procedures must be provided to the residents and residents' legal and designated representatives at the time of move-in. The policies could be provided in electronic format if desired. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02110		

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

Type: Full
Date: *11/07/23*
Time: 10:30:00
Report: 1006231142

Food and Beverage Establishment Inspection Report

Location:

Open Arms Senior Living
4414 Martin Road
Duluth, MN55803
St. Louis County, 69

Establishment Info:

ID #: 0042224
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.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Chlorine: = 50 PPM at Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Quaternary Ammonia: = 400 PPM at Degrees Fahrenheit
Location: 3 COMP SINK DISPENSER
Violation Issued: No

Quaternary Ammonia: = 400 PPM at Degrees Fahrenheit
Location: SANITIZER SPRAY BOTTLE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Freezer
Temperature: Degrees Fahrenheit - Location: ALL FOODS FROZEN
Violation Issued: No

Process/Item: Upright Freezer
Temperature: Degrees Fahrenheit - Location: ALL FOODS FROZEN
Violation Issued: No

Process/Item: Hot Holding
Temperature: 137 Degrees Fahrenheit - Location: NACHO CHEESE
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 37 Degrees Fahrenheit - Location: EGG SALAD
Violation Issued: No

Type: Full
Date: *11/07/23*
Time: 10:30:00
Report: 1006231142
Open Arms Senior Living

Food and Beverage Establishment Inspection Report

Process/Item: Walk-In Cooler
Temperature: 35 Degrees Fahrenheit - Location: GOULASH
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 37 Degrees Fahrenheit - Location: CHEDDAR CHEESE
Violation Issued: No

Process/Item: Upright Freezer
Temperature: Degrees Fahrenheit - Location: ALL FOODS FROZEN
Violation Issued: No

Process/Item: Upright Freezer
Temperature: Degrees Fahrenheit - Location: ALL FOODS FROZEN
Violation Issued: No

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

COMMENTS:

INSPECTION ACCOMPANIED BY KITCHEN MANAGER, DENESE KOPNICK.

KITCHEN IS CLEAN AND ORDERLY.

OBSERVED GOOD HAND WASHING AND GLOVE USE THROUGHOUT THE INSPECTION. DISCUSSED THE IMPORTANCE OF PROPER HAND WASHING AND EXCLUDING BARE HAND CONTACT WITH ALL READY TO EAT FOODS.

DISCUSSED THE EMPLOYEE ILLNESS POLICY AND THE EXCLUSION OF EMPLOYEES SICK WITH SYMPTOMS OF VOMITING AND/OR DIARRHEA UNTIL THEY HAVE BEEN SYMPTOM FREE FOR AT LEAST 24 HOURS. ALSO, CONTACT THE DEPARTMENT OF HEALTH IF ANY EMPLOYEES ARE DIAGNOSED WITH HEPATITIS A., SHIGA TOXIN-PRODUCING E. COLI, SALMONELLA, SHIGELLA, OR NOROVIRUS OR IF THERE ARE ANY SUSPECTED FOODBORNE ILLNESS COMPLAINTS.

Type: Full
Date: *11/07/23*
Time: 10:30:00
Report: 1006231142
Open Arms Senior Living

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 1006231142 of 11/07/23.

Certified Food Protection Manager: Jeremiah J. valentine

Certification Number: FM112882 Expires: 08/30/25

Inspection report reviewed with person in charge and emailed.

Signed:_____
Denese Kopnick
Kitchen Manager

Signed:_____
Callie Harrison

218-302-6173
callie.harrison@state.mn.us

Report #: 1006231142

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

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

No. of RF/PHI Categories Out	0
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 11/07/23
Time In 10:30:00
Time Out

Open Arms Senior Living	Address: 4414 Martin Road	City/State: Duluth, MN	Zip Code: 55803	Telephone
License/Permit #: 0042224	Permit Holder	Purpose of Inspection: Full	Est Type	Risk Category

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		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:** 11/09/23

Inspector (Signature)