Electronically Delivered

May 17, 2024

Licensee
Morning Star Health Care Services
6400 Georgia Avenue North
Minneapolis, MN 55428

RE: Project Number(s) SL35875015

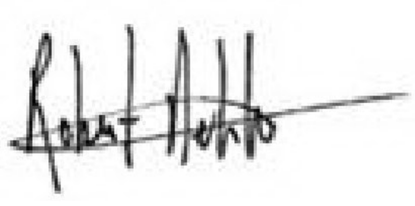
Dear Licensee:

On May 9, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the February 14, 2024, survey were corrected. This follow-up survey verified that the facility isin 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,



Bob Dehler, Supervisor
State Evaluation Team
Email: Robert.Dehler@state.mn.us
Telephone: 651-201-3710 Fax: 1-866-890-9290

HHH

Electronically Delivered

March 6, 2024

Licensee
Morning Star Health Care Services
6400 Georgia Avenue North
Minneapolis, MN 55428

RE: Project Number(s) SL35875015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 14, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E..

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

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

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

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
MDH may impose 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. MDH 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 (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 survey:

St - 0 - 0820 - 144g.45 Subd. 2 (g) - Fire Protection And Physical Environment - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a

hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 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
	35875	A. BUILDING: _____ B. WING _____	02/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTH CARE SER	6400 GEORGIA AVENUE NORTH MINNEAPOLIS, MN 55428

(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: SL35875015 On February 12, 2024 through February 14, 2024, 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 three (3) active residents receiving services under the assisted living license. An immediate order for tag identification 0820 was issued on February 12, 2024, at 4:25 p.m. The immediacy of correction order 0820 was removed on February 15, 2020, at 9:11 a.m., however noncompliance remains at a scope and level of G.	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.	
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an	0 110		

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0 110	Continued From page 1 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 licensed assisted living director (LALD)-D 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 the potential to affect a large portion or all the residents). The findings include: On February 4, 2024, at 7:31 p.m., the Minnesota Board of Executives for Long-Term Services and Support (BELTSS) website indicated LALD-D currently held a LALD license effective through October 31, 2024; however, LALD-D's license failed to identify LALD-D as the Director of Record for the licensee. During the entrance conference on February 12, 2024, at approximately 10:15 a.m., LALD-D stated they did not know they were not listed as director of record for licensee and stated they would get that corrected. No further information was provided.	0 110		

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0 110	Continued From page 2 TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated February 12, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer	0 480		

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0 480	Continued From page 3 to the FBEIR for any compliance dates.	0 480		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee's posted grievance procedure failed to include the contact information for the Offices of Ombudsman for Long-Term Care and Mental Health and Developmental Disabilities. This had the potential to affect all the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive	0 550		

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0 550	Continued From page 4 or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: During a facility tour on February 12, 2024, at approximately 11:00 am., the licensee's grievance policy was observed to be posted in the kitchen. However, the posting lacked the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. On February 13, 2024, at 1:08 p.m., licensed practical nurse (LPN)-A stated they were unaware that Ombudsman information needed to be included in the grievance posting. The licensee's Grievance policy dated January 24, 2022, indicated the grievance procedure would be conspicuously posted in the residence and would include contact information for the state and regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must	0 650		

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0 650	Continued From page 5 include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records included all required content for one of two employees (unlicensed personnel (ULP)-C). 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 employees are involved, or the situation has occurred only occasionally). The findings include:	0 650		

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0 650	Continued From page 6 ULP-C was hired October 31, 2021, to provide assisted living services to the licensee's residents. ULP-C's record lacked documentation of annual performance reviews that identified areas of improvement needed and training needs. On February 13, 2024, at 3:01 p.m., licensed practical nurse (LPN)-A stated they complete performance evaluations for all employees and did not know why it was missing from the employee record. The licensee's Personnel Records policy dated January 24, 2022, indicated each employee record would contain documentation of annual performance reviews identifying areas of improvement needed and training needs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents;	0 680		

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0 680	Continued From page 7 (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 (EP) plan with all required content. This had the potential to affect all residents, employees, and visitors to 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). The findings include: On February 13, 2024, at approximately 2:00 p.m., licensed practical nurse (LPN)-A provided two binders and indicated the contents were the licensee's EP plan. The licensee's EP plan dated 2018, lacked:	0 680		

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0 680	Continued From page 8 -policy and procedure addressing use of volunteers; -policy and procedures addressing at minimum food, water, and pharmaceutical supplies; -policy and procedure addressing the facility's role under a waiver declared by Secretary in accordance with section 1135 of the Social Security Act; -communication plan to include names and contact information for staff, entities providing services under agreement, resident's physicians, other facilities, and volunteers; -emergency officials contact information; -emergency preparation testing -documentation of annual review of EP plan; and -documentation of quarterly review of missing resident plan. On February 13, 2024, at 3:01 p.m., LPN-A and clinical nurse specialist (CNS)-E stated the licensee's emergency preparedness plan lacked the above listed content. CNS-E stated they were currently updating policies for the EP plan. CNS-E provided an undated Policy/Guidelines document and indicated it was EP policies that they were currently updating. The licensee's Emergency Preparedness policy dated January 24, 2022, indicated the licensee's EP plan would be reviewed/updated at least annually. The licensee's Missing Resident policy dated July 11, 2020, did not indicate the frequency at which the facility's missing resident plan would be reviewed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 680		

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0 680	Continued From page 9 (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide working smoke alarm in sleeping room #3 and failed to provide smoke alarms that are interconnected so that the actuation of one alarm causes all alarms in the dwelling unit to actuate. This deficient condition had the ability to	0 780		

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0 780	Continued From page 10 affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On February 12, 2024, at 11:30 a.m., survey staff toured the facility with the licensed assisted living director (LALD)-D and unlicensed personnel (ULP)-B. During the tour, it was observed a smoke alarm was not installed in the resident's sleeping room #3 on the main level. On February 13, 2024, at 1:30 p.m., LALD -D installed a smoke alarm in resident's sleeping room #3, but not interconnected, so the actuation of one smoke alarm would cause all other alarms in the facility to actuate. During the interview on February 13, 2024, at 1:30 p.m., LALD -D confirmed that the smoke alarm in the resident room #3 was not interconnected and verified this deficient finding. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire	0 790		

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0 790	Continued From page 11 extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to perform the required annual maintenance on fire extinguishers and failed to provide adequately rated portable fire extinguishers as required. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On February 12, 2024, at 11:30 a.m., survey staff toured the facility with the licensed assisted living director (LALD)-D and unlicensed personnel (ULP)-B. During the tour, it was also observed the fire extinguishers did not have a service tag showing it had been inspected annually.	0 790		

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0 790	Continued From page 12 It was observed the fire extinguisher provided was 1-A:10-BC (size) rated and did not have at least one 2-A:10-B:C rated fire extinguisher as required. On February 12, 2024, at 12:50 p.m., during the interview, LALD-D verified that the required maintenance had not been completed and the facility did not have an appropriate size fire extinguisher. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: The licensee failed to maintain the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a	0 800		

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0 800	Continued From page 13 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On February 12, 2024, at 11:30 a.m., survey staff toured the facility with the licensed assisted living director (LALD)-D and unlicensed personnel (ULP)-B. During the facility tour, survey staff observed the following items: On the screened back porch, it was observed a number of ashtrays and burnt cigarette butts in a plastic bag in the garbage can. On the wooden deck outside of the back porch, it was observed that burnt, used cigarettes were being disposed of in a planter attached to the railing. The burnt, used cigarettes were being disposed of without a proper disposal container, creating a possible fire hazard. On February 12, 2024, at 11:30 a.m., LALD-D verified that the back porch is where residents smoke, but there was no fire-safe disposal container for smoking residents on the porch and wood deck. 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	0 810		

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0 810	Continued From page 14 rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) 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 interview and record review, the licensee failed to conduct required evacuation drills as required. 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	0 810		

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0 810	Continued From page 15 resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On February 13, 2024, at 10:00 a.m., License Assisted Living Director (LALD)-D provided documentation on the fire safety and evacuation plan (FSEP), fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute. Provided documentation indicated that the drills were conducted on 7/10/23 at 4:00 p.m., 1/30/23 at 11:00 a.m., 7/23/22 at 11:00 a.m., 1/10/22 at 4:00 p.m., 1/16/21 at 5: 00 p.m., and 7/14/21 at 8:00 p.m., with no further drills being documented. During the interview on February 13, 2024, at 10:00 a.m., LALD-D confirmed that the drills were conducted every six months only and verified there were no further documented drills for the facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 820 SS=G	144G.45 Subd. 2 (g) Fire protection and physical environment	0 820		

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0 820	Continued From page 16 (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 ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide a resident bedroom with the minimum window opening meeting the minimum state standard for egress. This affected the occupied resident in bedroom #2 on the main level. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On February 12, 2024, at 11:30 a.m., survey staff toured the facility with the licensed assisted living director (LALD)-D and unlicensed personnel	0 820		

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0 820	Continued From page 17 (ULP)-B. During the facility tour, survey staff observed the following items: It was observed that occupied resident bedroom #2 on the main level did not have windows that met the minimum size requirements for egress escape. The clear openable area of the opened windows measured 13 inches in height and 33 inches in width, with a total openable area of 429 square inches. The windows did not meet the minimum requirements for opening height and did not meet the minimum requirements for total openable area. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. Survey staff explained to LALD-D and ULP-B that at least one egress window in each bedroom must be provided to meet the minimum state standard for an egress window to be a complying bedroom for resident occupancy. LALD-D verbally confirmed the findings. On February 12, 2024, at 12:50 p.m., during the interview, survey staff explained to LALD-D that an immediate correction order was issued for the above finding. LALD-D acknowledged the above finding. No Further information was provided. TIME PERIOD FOR CORRECTION: Immediate An immediate order for tag identification 0820 was issued on February 12, 2024, at 4:25 p.m. The immediacy of correction order 0820 was removed on February 15, 2020, at 9:11 a.m.,	0 820		

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0 820	Continued From page 18 however noncompliance remains at a scope and level of G.	0 820		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's	01370		

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01370	Continued From page 19 family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure required competency training was completed for one of two unlicensed personnel (ULP)-B). 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-B was hired on June 5, 2023, and began providing assisted living services. On February 13, 2024, at 7:50 a.m., ULP-B was observed providing direct care services to residents. ULP-B's employee record lacked the following documentation of required competency training to be completed by a registered nurse (RN): -principles of person-centered planning/service delivery; -appropriate and safe techniques in personal hygiene and grooming, including: (i) care and use of hearing aids; and (iii) dressing and assisting with toileting;	01370		

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01370	Continued From page 20 -medication, exercise, and treatment reminders; -reading and recording temperature, pulse, and respirations of the resident; -safe transfer techniques and ambulation; -range of motion and positioning. On February 13, 2024, at 7:50 a.m., ULP-B stated he had received training on the computer and from licensed practical nurse (LPN)-A and clinical nurse supervisor (CNS)-E. On February 14, 2024, at 3:01 p.m., LPN-A stated that elements were missing from the training and the documentation of training had been completed on an incorrect form. LPN-A stated she was unaware if training had been provided on the missing elements. The licensee's Staff Competency policy dated January 24, 2022, indicated: "3. Training and competency evaluations of ULP's include the following: a) Documentation requirements for all services provided b) Reports of changes in the resident's condition to the supervisor designated by the facility c) Basic infection control, including blood-borne pathogens d) Maintenance of a clean and safe environment e) Appropriate and safe techniques in personal hygiene and grooming, including: i. hair care and bathing ii. care of teeth, gums, and oral prosthetic devices iii. care and use of hearing aids iv. dressing and assisting with toileting f) Training on the prevention of falls g) Standby assistance techniques and how to perform them h) Medication, exercise, and treatment	01370		

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01370	Continued From page 21 reminders i) Basic nutrition, meal preparation, food safety, and assistance with eating j) Preparation of modified diets as ordered by a licensed health professional k) Communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family l) awareness of confidentiality and privacy m) Understanding appropriate boundaries between staff and residents and the resident's family n) Procedures to use in handling various emergency situations o) Awareness of commonly used health technology equipment and assistive devices." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff	01440		

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01440	Continued From page 22 administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of direct supervision for one of two employees (unlicensed personnel (ULP)-B). 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of employees are involved, or the situation has occurred only occasionally). The findings include: ULP-B was hired on June 5, 2023, and began providing assisted living services. On February 13, 2024, at 7:50 a.m., ULP-B was observed passing medications to R4. ULP-B stated training was provided by clinical nurse supervisor (CNS)-E. ULP-B's employee record included four Home Health Aide Supervision forms all dated June 5, 2023.	01440		

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01440	Continued From page 23 On February 13, 2024, at 3:01 p.m., licensed practical nurse (LPN)-A stated the forms were mistakenly used to document orientation. LPN-A stated ULP-B's employee file did not contain documentation of a supervisory visit of delegated tasks and was not sure if the supervison had been completed. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) Days	01440		
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee	01530		

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MORNING STAR HEALTH CARE SER	6400 GEORGIA AVENUE NORTH MINNEAPOLIS, MN 55428

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01530	Continued From page 24 until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the required hours of dementia care training was received by two of two employees (unlicensed personnel (ULP)-B, ULP-C). Additionally, the licensee failed to ensure that one of two employees (ULP-C) had completed at least two (2) hours of training on topics related to dementia care for each twelve (12) months of employment thereafter. 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 the potential to affect a large portion or all the residents). The findings include: ULP-B was hired on June 5, 2023, and began providing assisted living services. ULP-B's employee record contained documentation that employee received six (6) hours of dementia care training during orientation instead of the required eight (8) hours. ULP-C was hired on October 31, 2021, and began providing assisted living services.	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35875	A. BUILDING: _____ B. WING _____	02/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTH CARE SER	6400 GEORGIA AVENUE NORTH MINNEAPOLIS, MN 55428

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01530	Continued From page 25 ULP-C's employee record contained documentation that employee received three and one-half (3.5) hours of initial training in dementia care. Additionally, ULP-C's employee record lacked documentation of training on topics related to dementia care for each 12 months of employment. On February 13, 2024, at 3:01 p.m., licensed practical nurse (LPN)-A verified the employee records of ULP-B and ULP-C lacked the required training for dementia care. LPN-A stated they were unaware the training had not been completed. The licensee's Dementia Education policy dated January 24, 2022, indicated direct care employees would complete at least 8 hours of initial education within 80 working hours of employment start date in the following topics: -an explanation of Alzheimer's disease and other dementias; -assistance with activities of daily living; -problem solving with challenging behaviors -communication skills -person-centered planning and service delivery. The licensee's Dementia Education policy dated January 22, 2024, also indicated direct care employees would complete at least 2 hours of education on topics related to dementia for each 12 months of employment thereafter. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35875	A. BUILDING: _____ B. WING _____	02/14/2024

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01620	Continued From page 26	01620		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment to include all areas required on the uniform assessment tool for two of two residents (R1, R2) and failed to ensure the comprehensive nursing assessments were completed within the required 90-day timeframe for one of two residents (R1).	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35875	A. BUILDING: _____ B. WING _____	02/14/2024

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01620	Continued From page 27 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 represents a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1 R1 was admitted on February 6, 2023, and began receiving assisted living services. R1's Service Plan dated February 6, 2023, indicated R1 received the services for medication management and supervision and assistance with dressing, grooming, and meal preparation. R1's Nurse Reassessment Visit dated February 21, 2023, May 7, 2023, and August 7, 2023, were each a two-page assessment and each lacked portions of the required content identified on the uniform assessment tool. The assessments indicated specific physical assessments to be completed and marked with a checkmark next to, "NC," which is an abbreviation for, "No Change." The assessments failed to be developed and address the required content per Minnesota Administrative Rule 4659.0150. R1's Nurse Reassessment Visits were completed on May 7, 2023, and August 7, 2023, indicating 92 days had passed between assessments. R1 was discharged on November 12, 2023, indicating 97 days had passed from the previous assessment completed on August 7, 2023.	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35875	A. BUILDING: _____ B. WING _____	02/14/2024

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01620	Continued From page 28 R2 R2 was admitted on January 12, 2024, and began receiving assisted living services. R2's Service Plan dated January 12, 2024, indicated R2 received services for medication management and reminders and supervision with dressing, grooming, and meal preparation. R2's Nurse Reassessment Visit dated January 24, 2024, was a two-page assessment and lacked portions of the required content identified on the uniform assessment tool. The assessment indicated specific physical assessments to be completed and marked with a check mark next to "NC", which is an abbreviation for "No Change". The assessment failed to be developed and address the required content per Minnesota Administrative Rule 4659.0150. On February 13, 2024, at 3:01 p.m., clinical nurse supervisor (CNS)-E stated they were unaware of the requirements of Minnesota Administrative Rule 4659.0150 Uniform Assessment Tool. CNS-E stated she was told by her consultant to use the two-page Nurse Reassessment Visit document. The Minnesota Administrative Rule 4659.0150, subpart B dated August 11, 2021, indicated the required content of the uniform assessment tool. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		

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

Type: Full
Date: *02/12/24*
Time: 12:30:00
Report: 8041241020

Food and Beverage Establishment Inspection Report

Location:
Morning Star Health Care Ser
6400 Georgia Avenue North
Minneapolis, MN55428
Hennepin County, 27

Establishment Info:
ID #: 0039257
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7637107025
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.

4-500 Equipment Maintenance and Operation

4-501.116 ***** Priority 2 *****

MN Rule 4626.0815 Use the sanitizer test kit or other device to accurately measure the concentration of the sanitizing solution.

ESTABLISHMENT IS USING QUATERNARY AMMONIUM SANITIZER SOLUTION FOR WIPING CLOTH STORAGE. NO SANITIZER TEST KIT ON SITE. ESTABLISHMENT WILL ORDER.

Comply By: 02/26/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

MN Rule 4626.1520A Clean and maintain all physical facilities clean.

FOOD DEBRIS OBSERVED ON THE WALL BEHIND THE STOVE AND AROUND SOME OF THE CABINETRY IN THE KITCHEN AREA.

Comply By: 02/19/24

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400 ppm at Degrees Fahrenheit
Location: sani bucket under sink
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: whirlpool refrigerator: milk
Violation Issued: No

Type: Full
Date: *02/12/24*
Time: 12:30:00
Report: 8041241020
Morning Star Health Care Ser

Food and Beverage Establishment Inspection Report

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

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

Inspection was completed with the Food Service Manager, Precious Ojika. Michelle Winters was the lead Health Regulation Division Nurse Evaluator. Facility had three residents on site at time of inspection. Meals are prepared on site by staff.

This establishment has a residential kitchen. Food must be prepared for same day service only. The kitchen has wood cabinets with a hollow base, a laminate countertop, popcorn ceiling and vinyl tile flooring. Cabinetry and finishes will be monitored and may be required to be upgraded if not maintained in good condition.

A two basin sink is located in the kitchen with one basin designated for handwashing. Establishment has a Bosch under counter dish machine with a sanitize cycle option and achieved a utensil surface temperature of at least 160F.

Discussed the following:
-Employee illness policy and logging requirements
-Handwashing
-Glove-use and bare hand contact
-Food storage and preventing cross contamination
-Date marking
-Vomit clean up procedures
-Restrictions concerning serving a highly susceptible population

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 8041241020 of 02/12/24.

Certified Food Protection Manager: Precious Ojika

Certification Number: fm18517 Expires: 12/13/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
Precious Ojika
Food Service Manager

Signed: Sarah Conboy
Sarah Conboy
Public Health San. Supervisor
651-201-3984
sarah.conboy@state.mn.us