Electronically Delivered

March 12, 2025

Licensee
Tristar Home Care LLC
3000 80th Avenue North
Brooklyn Park, MN 55444

RE: Project Number(s) SL35697016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 5, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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
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.

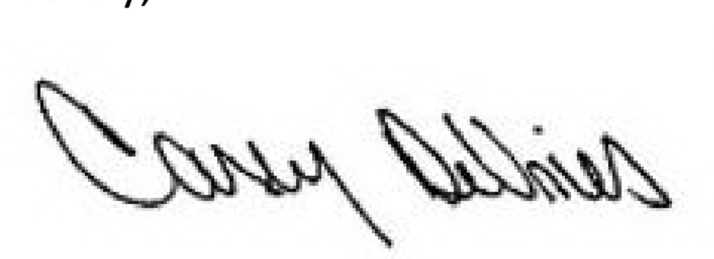
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

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

If you have any questions, please contact me.

Sincerely,



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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35697	A. BUILDING: _____ B. WING _____	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRISTAR HOME CARE LLC	3000 80TH AVENUE NORTH BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL35697016-0 On February 3, 2024, through February 5, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were three residents, all of whom received services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480		

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated February 3, 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		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a written evidence of the facility risk assessment, and two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test 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 a	0 660		

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0 660	Continued From page 4 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: The licensee lacked a current facility TB risk assessment. ULP-B started employment with the licensee on May 20, 2024, to provide direct care to the assisted living residents. ULP-B's record included a TB baseline screening (history and symptom screen) completed on May 20, 2024, and a chest x-ray with a negative result completed on February 19, 2024. ULP-B's record lacked a positive TB test to correlate with the chest x-ray. On February 3, 2024, at 2:00 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated the licensee had completed a facility risk assessment, but they misplaced it in their office. CNS/LALD-A also stated ULP-B had completed a TB blood test and they were waiting on the results from the clinic. The Minnesota Department of Health's Assisted Living Resources and Frequently Asked Questions (FAQs) dated June 2024, indicated baseline TB screening includes: - assessing for current symptoms of active TB disease; - assessing TB history; and - testing for the presence of Mycobacterium tuberculosis by administering either a two-step tuberculin skin test (TST) or single TB blood test. The FAQs also indicated a chest x-ray alone is	0 660		

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0 660	Continued From page 5 not acceptable documentation, and that documentation must include: - documentation of a positive two-step Tuberculin Skin Test (TST) or Interferon-Gamma Release Assay (IGRA) test; and - a chest x-ray (CXR) with provider evaluation after that date. The licensee's TB Prevention and Control policy dated August 1, 2021, indicated upon hire staff will be screened for TB symptoms and tested for TB. Staff will not work in resident care areas or areas where there is potential contact or shared space with residents until TB testing and screening is completed and a negative TB test is provided. If the first step of the two-step TST is negative the employee may begin working with residents (if the TST is dated within 90 days before hire) but must have the second TST test within 21 days after hire. Also indicated a chest x-ray will be accepted if the staff member has a negative chest x-ray and the positive Mantoux test that required the chest x-ray. The chest x-ray must be 90-days prior to or any time after the positive Mantoux test. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate	0 780		

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0 780	Continued From page 6 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 provide interconnected smoke alarms. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On February 4, 2025, at approximately 11:00	0 780		

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0 780	Continued From page 7 a.m., the surveyor toured the facility with licensed assisted living director (LALD)-A. During the tour, the surveyor observed the smoke alarms were tested for interconnection by the licensee, the dwelling unit smoke alarms were not interconnected as required by state statute. During the facility tour interview on February 4, 2025, LALD-A acknowledged the observation while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 790		

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0 790	Continued From page 8 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On February 4, 2025, at approximately 11:00 a.m., the surveyor toured the facility with licensed assisted living director (LALD)-A. The portable fire extinguishers throughout the facility lacked records to show monthly visual inspections were complete. On February 4, 2025, survey staff explained to LALD-A that the portable fire extinguishers must be provided monthly visual inspections or "quick checks" of each extinguisher by their employees to ensure all portable extinguishers are readily available, fully charged, and operable at their designated location with no obvious physical damage or condition to the extinguisher that would prevent their operation when needed. LALD-A stated they understood the requirements. No further information was provided. 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	0 800		

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0 800	Continued From page 9 residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 4, 2025, at approximately 11:30 a.m., the surveyor toured the facility with licensed assisted living director (LALD)-A. The following was observed. GENERAL MAINTENANCE: The main level bathroom sink had caulking that was peeling, missing, and was not properly sealed to the floor allowing the potential of water damage and unsanitary conditions. On February 4, 2025, at 1:30 p.m., LALD-A stated	0 800		

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0 800	Continued From page 10 they understood the above-listed deficiencies. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	0 810		

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0 810	Continued From page 11 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On February 4, 2025, at approximately 11:30 a.m., the surveyor observed the bedroom identification did not match the exit plan diagrams outlined in the FSEP. The exit plan diagrams must be correctly labeled to reduce confusion in a fire or similar emergency. On February 4, 2025, licensed assisted living director (LALD)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, failed to include the following: The FSEP included standard employee	0 810		

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(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
0 810	Continued From page 12 procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine and Extinguish or Evacuate) but failed to include procedures for how staff are to complete each step. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. On February 4, 2025, stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. LALD-A lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. The licensee failed to provide training to employees on the FSEP upon hire and at least	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35697	A. BUILDING: _____ B. WING _____	02/05/2025

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0 810	Continued From page 13 twice per year. On February 4, 2025, LALD-A stated they understood the requirements for training residents and staff and would implement a training program that was compliant with statute requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01370 SS=F	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	01370		

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01370	Continued From page 14 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 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 interview and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for two of two employees (unlicensed personnel (ULP)-B, 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-B ULP-B started employment with the licensee on May 20, 2024, to provide direct care services to residents. On February 4, 2025, at 10:55 a.m., ULP-B	01370		

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01370	Continued From page 15 stated they had completed a one week training before they shadowed another ULP. ULP-B also stated they could not remember the topics covered in the training. ULP-B's training record lacked the following required content: TRAINING - documentation requirements for all services provided; - reports of changes in the resident's condition to the supervisor designated by the assisted living provider; - maintenance of a clean and safe environment; - communication skills that include preserving the dignity of the resident; - understanding appropriate boundaries between staff and residents and the resident's family; - procedures to utilize in handling various emergency situations; and - awareness of commonly used health technology equipment and assistive devices. COMPETENCY - 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. ULP-C ULP-C started employment with the licensee on March 13, 2024, to provide direct care services to residents. ULP-C's training record lacked the following required content: TRAINING - documentation requirements for all services	01370		

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01370	Continued From page 16 provided; - reports of changes in the resident's condition to the supervisor designated by the assisted living provider; - basic nutrition, meal preparation, food safety, and assistance with eating; - preparation of modified diets as ordered by a licensed health professional; - understanding appropriate boundaries between staff and residents and the resident's family; and - awareness of commonly used health technology equipment and assistive devices. COMPETENCY - 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. On February 4, 2025, at 10:40 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated the licensee had recently started to renovate their office space, and that they misplaced many documents including employee records as they moved things around. CNS/LALD-A also stated they believed all staff completed the required training before starting to work with residents. The licensee's Staff Competency policy dated August 1, 2021, indicated all residents will receive quality service delivered by staff who are educated and competent in the delivery of the assisted living services. The policy included training in all the missing topics above. No further information was provided.	01370		

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01370	Continued From page 17 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for two of two employees (unlicensed personnel (ULP)-B, 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	01380		

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01380	Continued From page 18 or has the potential to affect a large portion or all of the residents). The findings include: ULP-B ULP-B started employment with the licensee on May 20, 2024, to provide direct care services to residents. On February 4, 2025, at 10:55 a.m., ULP-B stated they had completed a one week training before they shadowed another ULP. ULP-B also stated they could not remember the topics covered in the training. ULP-B's training record lacked the following required content: TRAINING - observation, reporting, and documenting of resident status; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; and - recognizing physical, emotional, cognitive, and developmental needs of the resident. COMPETENCY - reading and recording temperature, pulse, and respirations of the resident; - safe transfer techniques and ambulation; and - range of motioning and positioning. ULP-C ULP-C started employment with the licensee on March 13, 2024, to provide direct care services to residents. ULP-C's training record lacked the following required content:	01380		

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01380	Continued From page 19 TRAINING - observation, reporting, and documenting of resident status; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; and - recognizing physical, emotional, cognitive, and developmental needs of the resident. COMPETENCY - safe transfer techniques and ambulation; and - range of motioning and positioning. On February 4, 2025, at 10:40 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated the licensee had recently started to renovate their office space, and that they misplaced many documents including employee records as they moved things around. CNS/LALD-A also stated they believed all staff completed the required training before starting to work with residents. The licensee's Staff Competency policy dated August 1, 2021, indicated all residents will receive quality service delivered by staff who are educated and competent in the delivery of the assisted living services. The policy included training in all the missing topics above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or	01440		

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01440	Continued From page 20 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 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 a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for two of two employees (unlicensed personnel (ULP)-B, 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	01440		

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01440	Continued From page 21 The findings include: ULP-B ULP-B started employment with the licensee on May 20, 2024, to provide direct care services to residents. On February 4, 2025, between 8:15 a.m., and 9:30 a.m., the surveyor observed ULP-B administer medications to the licensee's residents. On February 4, 2025, at 9:10 a.m., the surveyor observed ULP-B gather blood glucose supplies and complete a blood glucose check for R2. ULP-C ULP-C started employment with the licensee on March 13, 2024, to provide direct care services to residents. R2's medication administration record dated January 2025, indicated ULP-C was administering medications to R2 in the evenings. ULP-B and ULP-C's employee record lacked evidence a RN 30-day supervision was completed. On February 4, 2025, at 3:00 p.m., RN-D stated they were not aware a 30-day supervision was supposed to be completed and documented. RN-D stated they regularly observed the staff when doing medication administration however, there was no documented evidence. The licensee's Supervision: Unlicensed Staff policy dated August 1, 2021, indicated home health aides providing services to assisted living	01440		

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01440	Continued From page 22 residents will be supervised to assure that the work is being performed competently and to identify problems and solutions to address issues relating to the employee's ability to provide the services to the residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and	01470		

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01470	Continued From page 23 Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received orientation to assisted living facility licensing requirements and regulations prior to providing services for two of two employees (unlicensed personnel (ULP)-B, ULP-C).	01470		

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01470	Continued From page 24 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-B ULP-B started employment with the licensee on May 20, 2024, to provide direct care services to residents. On February 4, 2025, at 10:55 a.m., ULP-B stated they had completed a one week training before they shadowed another ULP. ULP-B also stated they could not remember the topics covered in the training. ULP-B's training record lacked the following required orientation topics: - overview of assisted living statutes; - review of provider's policies and procedures; - handling emergencies and using emergency services; - assisted living bill of rights; - handing of resident complaints, reporting of complaints, where to report; and - principles of person-centered planning/service delivery. ULP-C ULP-C started employment with the licensee on March 13, 2024, to provide direct care services to residents.	01470		

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01470	Continued From page 25 ULP-C's training record lacked the following required orientation topics: - overview of assisted living statutes; - review of provider's policies and procedures; - assisted living bill of rights; - handing of resident complaints, reporting of complaints, where to report; - consumer advocacy services; - review of types of assisted living services the employee will provide and provider's scope of license; and - principles of person-centered planning/service delivery. On February 4, 2025, at 10:40 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated the licensee had recently started to renovate their office space, and that they misplaced many documents including employee records as they moved things around. CNS/LALD-A also stated they believed all staff completed the required training before starting to work with residents. The licensee's Staff Orientation and Education policy dated August 1, 2021, indicated all staff providing assisted living through [licensee] will be prepared to provide safe, effective services to all residents through a thorough orientation and education program pertinent to the needs of the residents. The policy included all the required topics missing above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		

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01940	Continued From page 26	01940		
01940 SS=F	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: Based on observation, interview, and record review, the licensee failed to develop and implement a current treatment or therapy management plan to include all required content	01940		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRISTAR HOME CARE LLC	3000 80TH AVENUE NORTH BROOKLYN PARK, MN 55444

(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
01940	Continued From page 27 for one of one resident (R2) with blood glucose monitoring. In addition, the licensee failed to include the treatment in the service plan. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 was admitted to the licensee on March 1, 2024, and began to receive assisted living services. On February 4, 2025, at 9:10 a.m., the surveyor observed unlicensed personnel (ULP)-B complete a blood glucose check for R2 and stated the reading was 113 milligrams/deciliter (mg/dL) R2's diagnoses included type two diabetes without complication, insomnia, vitamin D deficiency, chronic pulmonary disease unspecified (COPD), bipolar disorder, and anxiety. R2's Service Plan (Waiver) - Addendum to Contract dated June 16, 2024, indicated R2 received the following services: medication administration, antipsychotic monitoring, behavior management, housekeeping, and safety checks. R2's service plan lacked blood glucose monitoring as a service provided to R2 and the frequency of the service. R2's provider orders for blood glucose monitoring	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35697	A. BUILDING: _____ B. WING _____	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRISTAR HOME CARE LLC	3000 80TH AVENUE NORTH BROOKLYN PARK, MN 55444

(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
01940	Continued From page 28 dated December 4, 2024, indicated check blood glucose once per day. R2's blood glucose monitoring record dated between January 4, 2025, and February 4, 2025, indicated R2's blood glucose ranged between 89 mg/dL and 216 mg/dL. R2's record lacked a treatment or therapy management plan that included the following required content: - a statement of the type of services that will be provided; - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and - 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. On February 4, 2025, at 3:00 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated they were aware of the requirement for a treatment or therapy management plan. CNS/LALD-A also stated they had missed it in their admission assessment, and that they had missed it even their medication administration record (MAR). Further, CNS/LALD-A stated they were not aware the treatment needed to be included in the resident service plan.	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35697	A. BUILDING: _____ B. WING _____	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRISTAR HOME CARE LLC	3000 80TH AVENUE NORTH BROOKLYN PARK, MN 55444

(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
01940	Continued From page 29 The licensee's Medication, Treatment and Therapy policy dated August 1, 2022, indicated residents will receive medication, treatment, and therapy reminders per RN assessment and provider orders. The policy lacked verbiage to include the content for an individualized treatment and therapy management plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		

Minnesota Department of Health

3333 Division St #212
St. Cloud
320 223-7300

Type: Full
Date: *02/03/25*
Time: 22:30:00
Report: 1051251025

Food and Beverage Establishment Inspection Report

Location:

Tristar Home Care Llc
3000 80th Avenue North
Brooklyn Park, MN55444
Hennepin County, 27

Establishment Info:

ID #: 0038642
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7634155471
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.

4-300 Equipment Numbers and Capacities

4-302.12B ***** Priority 2 *****

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

AT TIME OF INSPECTION, THERE IS NO THIN-TIPPED THERMOMETER.
Comply By: 02/10/25

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.111C ***** Priority 2 *****

MN Rule 4626.1565C Use approved trapping devices or other means of pest control when pests are found.

DISCONTINUE USING SNAPTRAPS FOR MICE. A PEST CONTROL COMPANY WAS CONTACTED LAST WEEK. THE REGISTERED NURSE DISCARDED THE SNAPTRAP. CORRECTED ON SITE.
Corrected on Site

2-100 Supervision

2-102.12AMN

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

AT TIME OF INSPECTION, THERE IS NO CFPM. MARIA IS SIGNED UP FOR A TRAINING CLASS & WILL BE ATTENDING THE CLASS NEXT WEEK.
Comply By: 02/24/25

4-200 Equipment Design and Construction

4-204.112D

MN Rule 4626.0620D Provide a temperature measuring device that is easily readable.

THE UPRIGHT COOLER IN THE LOWER FLOOR NEEDS A THERMOMETER.
Comply By: 02/10/25

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

THE RESTROOM IN THE MAIN FLOOR NEEDS A HANDWASH SIGN.
Comply By: 02/03/25

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: AMBIENT-MAIN KITCHEN
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: MILK-BASEMENT
Violation Issued: No

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

MET WITH NURSE EVALUATOR, BENARD NYANGENA

DISCUSSED THE FOLLOWING WITH THE FACILITY REGISTERED NURSE, MARIA:

EMPLOYEE ILLNESS LOG
VOMIT CLEAN-UP PROCEDURE
CERTIFIED FOOD PROTECTION MANAGER
APPROVED TRAPPING DEVICE

THE KITCHEN HAS A NSF 184 DISHMACHINE, LAMINATE CABINETS & COUNTERTOPS WITH HOLLOW BASES, POPCORN TEXTURE CEILING, AND VINYL PLANK FLOORS.

Type: Full
Date: *02/03/25*
Time: 22:30:00
Report: 1051251025
Tristar Home Care Llc

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 1051251025 of 02/03/25.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____
Maria
Registered Nurse

Signed:_____
Kai Yang
Public Health Sanitarian 1
St. Cloud
320 640-3532
Kai.Yang@state.mn.us