DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery

February 4, 2026

Licensee
Morning Star Healthcare Services
2925 Regent Avenue North
Crystal, MN 55422

RE: License Number 419443
Health Facility Identification Number (HFID) 29038
Project Number(s) SL29038016

Dear Licensee:

On January 20, 2026, The Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed December 6, 2024. The follow-up survey found the facility to be in substantial compliance. **Based on these findings, the condition(s) on the license were removed effective February 4, 2026.**

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

Sincerely,

Rick Michals

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

HHH

Electronically Delivered

June 24, 2025

In the Matter of Morning Star Healthcare Services
Morning Star Healthcare Services
2925 Regent Avenue North
Crystal, MN 55422

RE: MDH Health Facility Identification Number 29038
License Number 419443
Project Number(s) SL29038016

STIPULATION AND CONSENT ORDER:
It is stipulated and agreed by Morning Star Healthcare Services and the Minnesota Department of Health ("Department" or “MDH”), that without a hearing or adjudication under the procedures outlines in Minn. Stat. § 144G.20 and/or Minn. Stat § 144G.32, both parties agree to enter into this Stipulation and Consent Order.

This Stipulation and Consent Order (“Stipulation”), survey results, dated December 6, 2024, and related enforcement and investigation documents shall constitute the entire record upon which this Stipulation is based. These documents, dated through the date of this Stipulation, listed below in the Facts and Law, are incorporated by reference into this Stipulation.

FACTS AND LAWS:

1. Minn. Stat. § 144G.01 - Minn. Stat. § 144G.95, authorize MDH to regulate licensed assisted living facilities in Minnesota. This authority includes issuing licenses and conducting surveys to determine if a license holder complies with statutory requirements of licensed assisted living facilities.

2. The Assisted Living Facility located at 2925 REGENT AVENUE NORTH, Golden Valley, MN 55422, with HFID 29038, has been licensed to provide assisted living services since August 1, 2021.

3. On December 6, 2024, the Department conducted a change of ownership (CHOW) survey for the purpose of assessing compliance with State licensing regulations (Project Number SL29038016). This survey resulted in 28 orders, including 21 Level 2/Widespread and two Level 3/Widespread.

4. MDH sent a letter on March 14, 2024, informing Morning Star Healthcare Services of the violations and fines imposed. The enforcement letter notified Morning Star Healthcare Services of its options to exercise hearing rights and reconsideration rights. Additionally, the letter instructed Morning Star Healthcare Services to contact

MDH to schedule an informal conference.

5. On May 7, 2025, MDH conducted a follow-up survey to determine correction of orders found on the survey conducted on December 6, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the December 6, 2024, survey as well as the issuance of new orders, resulting in 25 orders, including 23 Level 2/Widespread and one Level 3/Widespread.

CURRENT STATUS:
Morning Star Healthcare Services Owner, Larry Ubani, met informally with MDH during a conference call on March 27, 2025.

Morning Star Healthcare Services was informed of the opportunity to have representation (including a lawyer) present during this informal conference. During this call, MDH shared their concerns about the survey completed on December 6, 2024, and provided Morning Star Healthcare Services with the option of a Stipulation and Consent Order to resolve those concerns and fines. During the informal conference, Morning Star Healthcare Services shared what actions they are taking to bring Morning Star Healthcare Services into compliance.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on December 6, 2024, found not corrected at the time of the May 7, 2025, follow-up survey are as follows:

0250-Conditions-144g.20 Subdivision 1
0650-Staff Records-144g.42 Subd. 8 (a)
0660-Tuberculosis Prevention And Control-144g.42 Subd. 9
0680-Disaster Planning And Emergency Preparedness-144g.42 Subd. 10
0970-Waivers Of Liability Prohibited-144g.50 Subd. 5
1360-Instructor And Competency Evaluation Requirem-144g.61 Subdivision 1
1390-Availability Of Contact Person To Staff-144g.62 Subdivision 1
1420-Delegation Of Assisted Living Services-144g.62 Subd. 2
1620-Initial Reviews, Assessments, And Monitoring-144g.70 Subd. 2 (c-E)
1640-Service Plan, Implementation And Revisions To-144g.70 Subd. 4 (a-E)
1750-Delegation Of Medication Administration-144g.71 Subd. 7
1760-Documentation Of Administration Of Medication-144g.71 Subd. 8
1880-Storage Of Medications-144g.71 Subd. 19
1940-Individualized Treatment Or Therapy Managemen-144g.72 Subd. 3
1950-Administration Of Treatments And Therapy-144g.72 Subd. 4
1970-Treatment And Therapy Orders-144g.72 Subd. 6

The details of the violations noted at the time of this follow-up survey completed on May 7, 2025, (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand Column, e.g., {2 ----} will identify the uncorrected tags.

Also, at the time of this follow-up survey completed on May 7, 2025, we identified the following

violation(s):

0340-Correction Orders-144g.30 Subd. 5 - 500.00
0495-Minimum Requirements-144g.41 Subdivision. 1 (13)
0730-Contents Of Resident Record-144g.43 Subd. 3
1330-Unlicensed Personnel-144g.60 Subd. 4 (b)
1440-Supervision Of Staff Providing Delegated Nurs-144g.62 Subd. 4
1650-Service Plan, Implementation And Revisions To-144g.70 Subd. 4 (f)
1710-Individualized Medication Monitoring And Reas-144g.71 Subd. 3
1730-Individualized Medication Management Plan-144g.71 Subd. 5
1820-Prescriptions-144g.71 Subd. 13

The details of the violation(s) noted at the time of this follow-up survey are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state correction orders. It is not necessary to develop a plan of correction.

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 and immediately correct any reissued orders outlined on the state form; however, plans of correction are not required to be submitted for approval.

CONDITIONAL LICENSE ISSUED:
Under this Stipulation and Consent Order, MDH will issue Morning Star Healthcare Services a conditional assisted living facility license for 90 calendar days from the date this Stipulation is fully executed (signed). Conditional licenses are addressed in Minn. Stat. § 144G.20. The conditions will be effective immediately upon execution of this Stipulation. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30 Subd. 6. Based on the results of the survey, MDH will determine if Morning Star Healthcare Services is in compliance with 144G and the conditions imposed by this Stipulation. If the licensee is in substantial compliance, conditions will be lifted.

The following conditions apply on the conditional assisted living facility license:

a. **No new substantiated maltreatment allegations:** If any new investigations begin in the conditional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the license.

b. **No new admissions:** Morning Star Healthcare Services will not admit any new residents under its conditional assisted living facility license until MDH removes the “no new admissions” condition. Morning Star Healthcare Services must provide the Department:

    i. A list of the names and birthdates of any individuals Morning Star Healthcare Services is currently in the process of admitting. These

individuals will be able to continue the admittance process.

ii. A list of all current residents:
    1. Name and birthdate of each resident
    2. Current payment source for services
    3. If Elderly Waiver, the name and contact information of the care coordinator/case manager
    4. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative

c. **Consultant:** Morning Star Healthcare Services will contract with an RN to provide consultation concerning all resident(s) to whom Morning Star Healthcare Services provides licensed assisted living services under the conditional license. The consultant must have access to all resident(s) receiving services from Morning Star Healthcare Services. The consultant will conduct initial and ongoing evaluations of the provider. Direct resident observation may be required based on the consultant's judgement or at the discretion of MDH. The RN must not have any affiliation with Morning Star Healthcare Services and MDH must review the RN's credentials and approve the selection. Morning Star Healthcare Services is responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to Morning Star Healthcare Services in an effort to help Morning Star Healthcare Services align their practices with the requirements of Minn. Stat. §§ 144G.01 – 144G.9999 and to provide oral and written reports to MDH noting progress toward substantial compliance and/or concerns about observations. Morning Star Healthcare Services will develop and implement policies, procedures, and processes specific to the offered services in accordance with the guidance provided by the consultant to ensure ongoing monitoring and substantial compliance with statutory requirements.

d. **Reports:** The RN consultant will provide MDH with regular reports at intervals specified by MDH. Reports will begin on a weekly basis until MDH notifies Morning Star Healthcare Services and the RN consultant about a change. Each report will be electronically submitted to: HRDConsultantReports.MDH@state.mn.us. The content of the reports will include information such as:

    i. Progress towards correction of orders;
    ii. Observations of staff delivering assisted living services and the level of competency observed;
    iii. Conversations with residents and family members about satisfaction with assisted living services;
    iv. Conversations with staff about their level of knowledge about the tasks they perform, the people they serve and the health professionals who

delegate to them;

v. Overall impressions about the quality of the assisted living services delivered;
vi. Overall impressions about the dignity with which the residents and their family members are treated;
vii. Concerns; and
viii. Any other information requested by the Department or considered important by the RN consultant(s).

e. **Monitoring visits:** MDH may make unannounced follow up surveys under Minn. Stat. § 144G.30 subds. 6 and 7 to assess the progress of Morning Star Healthcare Services to correct the violations cited during the follow-up survey as well as to determine the overall practice of Morning Star Healthcare Services in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive licensed assisted living services. The OOLTC will share their findings with MDH.

f. **Follow-up survey:** At the time of the follow-up survey, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the license if MDH identifies any level 3 or 4 violations or widespread care related violations.

g. **Corrective Action Plan:** Morning Star Healthcare Services will develop and work within a corrective action plan (CAP)(Minn. Stat. § 144G.30, Subd. 5 (c). The CAP is a working document that includes at least the following information:
    i. A statement of the concern
    ii. A description of what will happen to correct the concern
    iii. A target date for when each correction will be complete
    iv. Who is responsible to make sure it happens
    v. Current status of corrections
    vi. Description of a plan to monitor and ensure ongoing substantial compliance for each corrected order

RESULTS OF FOLLOW-UP SURVEY DURING THE CONDITIONAL LICENSE PERIOD: MDH will determine if Morning Star Healthcare Services is in compliance based on the results of the follow up survey conducted pursuant to Minn. Stat. § 144G.30, Sub. 6. MDH will make this determination within the 90-day conditional license period. If MDH determines Morning Star Healthcare Services is in substantial compliance on the follow up survey, MDH will remove the conditions from Morning Star Healthcare Services' assisted living facility license, and Morning Star Healthcare Services will correct violations detected during the survey to come into full compliance. If MDH determines Morning Star Healthcare Services is not in

substantial compliance, MDH may take additional enforcement action against Morning Star Healthcare Services, including placement of additional conditions, issuing a second conditional license, or employ any of the enforcement tools listed in Minn. Stat. § 144G.20 up to and including immediate temporary suspension and revocation.

RIGHTS AND WAIVERS:
Under this Stipulation, Morning Star Healthcare Services waives all hearing and reconsideration rights in Minn. Stat. § 144G.20 and Minn. Stat. § 144G.32 to dispute the referenced survey findings and the conditional assisted living facility license under the terms and duration noted above. Any pending requests for hearing or reconsideration related to these survey findings are rescinded. Morning Star Healthcare Services retains all applicable appeal rights outlined in Minn. Stat. Chapter 144G for any enforcement action not outlined in this agreement.

FINES RESCINDED:
Under this Stipulation, MDH rescinds the fines assessed in the March 14, 2025, letter concerning the survey completed on December 6, 2024. The rescinded fines include those associated with order number(s) 1390 and 2310 totaling $6,000.00. The correction orders outlined in the March 14, 2025, State Form remain in effect. Upon execution of this Stipulation, MDH will issue an amended enforcement letter to the licensee, rescinding the fines.

BINDING EFFECT:
This Stipulation is binding upon the Parties, the licensee (including their employees and/or contractors), and representatives. The Parties will assure that their employees, agents, heirs, administrators, representatives, and executors, are made aware of this Stipulation.

NO LIMITED AUTHORITY:
This Stipulation does not in any way or manner limit or affect the authority of MDH to take additional enforcement action against Morning Star Healthcare Services based on any act, conduct, or admission of Morning Star Healthcare Services which justifies enforcement action and occurred either before or after the date of this Stipulation and which is not directly related to the facts and circumstances covered in this Stipulation.

ENTIRE AGREEMENT AND ENFORCEMENT:
Parties agree this stipulation and consent order contains the entire agreement between Morning Star Healthcare Services and MDH related to the survey and supersedes any prior written or oral settlement discussions or agreement between the parties related to violations contained in the enforcement letter.

MDH will provide a signed electronic copy of the Stipulation to Morning Star Healthcare Services. Noncompliance with this Stipulation may result in further enforcement action under 144G and/or the pursuit of further legal remedies available under the law.

Except when used to enforce the terms of this Stipulation, this Stipulation does not constitute nor involve in any way an admission of MDH or Morning Star Healthcare Services or of any fact

or interpretation or law or rule.

DATA PRACTICES:
Parties agree that release of information from any Department file pertaining to this matter, including this agreement, is governed by the Minnesota Data Practices Act, Minn. Stat. ch. 13; the Official Records Act, Minn. Stat. §15.17; Minn. Stat. §144.051, and any other applicable law.

RIGHT TO COUNSEL AND ACKNOKWLEDGEMENT:
All parties acknowledge that they have been represented by counsel or have had the opportunity to retain counsel in this matter, have fully negotiated this Stipulation, and have not relied upon any statements by other parties, their employees, or agents in agreeing to this Stipulation.

EFFECTIVE DATE:
This Stipulation is effective upon the signature of the licensee and the MDH Commissioner or designee. As stated above, MDH will provide an electronic signed copy to Morning Star Healthcare Services once the appropriate MDH official has signed the document.

Morning Star Healthcare Services

_____
Larry Ubani, Owner

Date:_____, 2025

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

_____
Rick Michals, J.D., Executive Regional Operations Manager

Date:_____, 2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	R 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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 FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL29038016-1 On May 5, 2025, through May 7, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on December 6, 2024. At the time of the survey, there was one (1) resident receiving services under the Assisted Living License. As a result of the follow-up survey, the following orders were reissued and/ or issued.	{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.	
{0 250} SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a	{0 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	R 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
{0 250}	Continued From page 1 provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or staff of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or staff; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under	{0 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	R 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
{0 250}	Continued From page 2 section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide sufficient management, control, and operation of the housing and services provided by the facility. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: The licensee had an assisted living license, effective February 8, 2025. The licensee's (renewal) "Application for Assisted Living License", section titled "Official Verification	{0 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	R 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
{0 250}	Continued From page 3 of Owner or Authorized Agent", (page five and six of the application), identified an affirmative checkmark next to the statement, "I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659, governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract." Another checkmark was noted at the statement, "I have examined this application and all attachments, and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct and complete. I will notify MDH, in writing, of any changes to this information as required." Page six was electronically signed by the owner on January 16, 2025. As a result of this survey, the following orders were issued under 340, 495, 650, 660, 680, 0730, 970, 1330, 1360, 1390, 1420, 1440, 1620, 1640, 1650, 1710, 1730, 1750, 1760, 1820, 1830, 1880, 1940, 1950, and 1970, which indicated the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.01 to 144G.95. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	{0 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	R 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
0 340	Continued From page 4	0 340		
0 340 SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must: (1) document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide sufficient documentation with actions taken to comply with the correction orders from a survey completed December 6, 2024. The lack of action to ensure compliance with regulations had the potential to affect all residents receiving services from the licensee.	0 340		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	R 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
0 340	Continued From page 5 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: On March 14, 2025, the licensee received an enforcement letter, with the results of the survey completed December 6, 2024. The longest time period for correction was 21 days from March 14, 2025, or April 4, 2025. On May 5, 2025, at 10:10 a.m. during a phone call, licensed assisted living director (LALD)-A stated the licensee had not corrected citations and had not developed a plan of correction (POC) for citations issued during the licensee's survey completed on December 6, 2024. LALD-A stated the licensee was waiting until the licensee had established a contract with a consultant before the licensee would develop a POC. On May 5, 2025, at 11:17 a.m., LALD-A arrived at the facility and reiterated the licensee had not developed a written POC to address any of the citations issued and had not started working on correction citations until the licensee established a contract with a consultant. When asked why licensee had not followed the time period for correction listed at the end of each citation, LALD-A stated the licensee was under the impression they would wait until they had a consultant contracted before any correction would be completed.	0 340		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	R 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
0 340	Continued From page 6 No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340		
0 495 SS=F	144G.41 Subdivision. 1 (13) Minimum Requirements (13) provide staff access to an on-call registered nurse 24 hours per day, seven days per week. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) was available 24 hours a day, seven days a week. This had the potential to affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Clinical nurse supervisor (CNS)-M was hired December 3, 2024, and was identified by licensed assisted living director (LALD)-A as only RN employed by licensee. On May 5, 2025, at 10:10 a.m., during a phone call, LALD-A stated CNS-M was not available for the duration of the survey as CNS-M was out of	0 495		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	R 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
0 495	Continued From page 7 the country. LALD-A stated no other RN was available as a backup RN, while CNS-M was not available. LALD-A stated CNS-M had left sometime at the end of April 2025, but was not sure of the exact date and was expected to return on May 10, 2025. On May 5, 2025, at 10:45 a.m., during a phone call, licensed practical nurse/owner (LPN/O)-E stated CNS-M was not available and LPN/O-E was the backup nurse until CNS-M returned. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 495		
{0 650} SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (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	{0 650}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	R 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
{0 650}	Continued From page 8 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 contained all required content for three of three unlicensed personnel ((ULP)-B, ULP-C, ULP-J). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On March 15, 2024, a change of ownership (CHOW) was completed transferring ownership from the previous licensee to the current licensee. ULP-B ULP-B was hired February 8, 2024. ULP-B's record lacked evidence an annual performance review identifying areas of improvement or training needed was completed. ULP-C ULP-C was hired September 25, 2024. ULP-C's record lacked records of training	{0 650}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	R 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
{0 650}	Continued From page 9 received, competency evaluations, and a current job description. ULP-J ULP-J was hired May 8, 2024. ULP-J's record lacked records of training received, competency evaluations, and a current job description. On May 5, 2025, at 12:50 p.m., licensed assisted living director (LALD)-A stated the licensee had not completed employee record audits since the CHOW was completed. LALD-A stated each employee's record would need to be audited and missing content placed in each record. The licensee's Personnel Records policy dated January 24, 2022, indicated all required content of each employee's record, including the identified missing items above. No further information provided.	{0 650}		
{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	{0 660}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	R 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
{0 660}	Continued From page 10 technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included documentation of a TB facility risk assessment completed as required. 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: On May 5, 2025, at 11:20 a.m., licensed assisted living directed (LALD)-A indicated they would provide the licensee's Facility TB Risk Assessment document. LALD-A indicated the assessment was maintained in the licensee's Survey Binder. On May 6, 2025, at 7:30 a.m., the licensee's Survey Binder, Policy and Procedure binder, and Forms and Manuals binder were reviewed. A blank Facility TB Risk Assessment template was noted in the Forms and Manuals binder. No completed Facility TB Risk Assessment was	{0 660}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	R 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
{0 660}	Continued From page 11 located or provided during the course of the survey. No further information was provided.	{0 660}		
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the	{0 680}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	R 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
{0 680}	Continued From page 12 required content. Additionally, the licensee failed to post an emergency disaster plan prominently. This had the potential to affect all residents receiving services under the assisted living license. 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: During facility tour on May 5, 2025, at 10:45 a.m., surveyor did not observe a EPP or a posting indicating where the EPP could be found. On May 6, 2025, at 7:30 a.m., licensee's the Emergency binder, Survey Binder, Policy and Procedure binder, and Forms and Manuals binder were located on a cabinet in the dining area and reviewed. The red Emergency binder contained blank documents and was not prominently posted in a common area. The licensee's EPP lacked evidence of the following required content: -develop and maintain the EP: -hazard vulnerability assessment; -arrangements/contracts to re-establish utility services; -maintain and annual EP updates: -failure to review Missing Resident Plan quarterly and implement the plan; -process for EP collaboration:	{0 680}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	R 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
{0 680}	Continued From page 13 -process for cooperation/collaboration with local, tribal, and regional EP; -development of EP policies and procedures; -subsistence needs for staff and patients: -address the following whether evacuated or shelter in place for staff/residents: -food, water, medical supplies, pharmaceutical supplies; -alternate sources of energy to maintain: -temperatures to protect resident health/safety; -safe/sanitary storage of provisions; -emergency lighting; -fire detection, extinguishing, alarm systems; and -sewage and waste disposal; -develop P/P (policies/procedures) to address system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records; -develop P/P that must address: use of volunteers, including the process/role for integration; -develop P/P to address role of facility under a waiver declared by the Secretary in accordance with section 1135 of the Act; -communication plan must include all the following names/contact information: staff, entities providing services under agreement, residents' physicians, other facilities, volunteers; -communication plan must include: primary and alternative means of communicating with: facility staff and Federal, State, tribal, regional & local emergency management agencies; -communication plan must include: method for sharing information and medical documentation for residents under the facility's care, as necessary with other health care providers (HCPs) to maintain continuity of care; -communication plan must include all of the following: means to providing information about the facility's occupancy needs, and it's ability to	{0 680}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	R 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
{0 680}	Continued From page 14 provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee; -communication plan must include all of the following: method for sharing information from the EP, that the facility has determined appropriate, with residents and their families/representatives; -must develop and maintain EP training and testing program: initial training in EP P/P to all new and existing staff, individuals providing services under arrangement, and volunteers consistent with their expected role, provide EP training at least annually and maintain documentation of all EP training; and -emergency prep testing requirements. During exit conference on May 7, 2025, at 10:30 a.m., owner/assistant administrator (O/AA)-I stated the licensee would need to develop, complete, and prominently post the licensee's EPP. O/AA-I stated the licensee would review the binder for missing content and correct the missing pieces. The licensee's Emergency Preparedness policy dated January 24, 2022, indicated the licensee would have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. No further information was provided.	{0 680}		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	R 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
0 730	Continued From page 15 number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	R 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
0 730	Continued From page 16 (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included documentation of coordination of cares provided for one of one resident (R1) who had palliative care services from an outside provider. 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 May 5, 2025, at 10:40 a.m., surveyor noted a person exit licensee's facility and identified themselves as registered nurse (RN)-L for Palliative Care Nurse Case Manager for a local home care company. RN-L stated that they were present to complete wound care services for R1 who was recently admitted to palliative care (specialized care with a goal of quality-of-life improvement when a person has a serious chronic illness). RN-L stated that R1 had been on hospice care but had a change of condition and was transitioned to palliative care a couple of weeks prior. RN-L stated they had not had contact from a RN employed by the licensee since R1's transition to palliative care.	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	R 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
0 730	Continued From page 17 R1 was admitted on February 7, 2020, with diagnoses including dementia, incontinence, aphasia, and history of breast cancer. R1's Service Plan dated February 8, 2024, indicated R1 required activities of daily living (ADLs), medication, and treatment management services. R1's Initial Assessment dated February 11, 2024, completed by clinical nurse supervisor (CNS)-D was indicated by licensed assisted living director (LALD)-A as R1's most recent assessment. A total of 449 days had passed since R1's previous assessment. R1's record lacked documenation of communication pertinent to the R1's palliative care services and documentation of significant changes in R1's status and actions taken in response to the needs of R1. On May 7, 2025, at 12:01 a.m., an email from CNS-M read, "Regarding resident records, I encountered some challenges navigating the ECP electronic charting system due to my limited familiarity. When hospice took over care, I wasn't certain whether additional assessments were required since the resident's status remained unchanged. However, I understand the importance of thorough documentation," and "Given my relatively short time at the facility (less than a year), I'm unsure if I should have completed the annual medication and treatment management assessment. Thank you for bringing this to my attention. I will verify staff training and competency documentation, resident assessments, and complete necessary assessments for delegated tasks."	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	R 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
0 730	Continued From page 18 On May 7, 2025, at 10:30 a.m., owner/assistant administrator (O/AA)-I stated CNS-M should have documented all coordination of care in R1's record. O/AA-I stated licensee routinely works with outside providers and licensee worked together with the outside providers based on the needs of the resident. The licensee's Coordination in the Medication Management Program policy dated January 24, 2022, indicated licensee would use a health care team-based approach to manage the needs of a resident when other providers are included in a resident's care and evidence of the coordination would be maintained in the resident record. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 730		
{0 970} SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal	{0 970}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	R 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
{0 970}	Continued From page 19 property for one of one resident (R1). 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 March 15, 2024, a change of ownership (CHOW) was completed transferring ownership from previous licensee to current licensee. R1 was admitted on February 7, 2020. R1's [licensee] Assisted Living Contract dated February 8, 2024, was identified as R1's current authenticated assisted living contract by licensed assisted living director (LALD)-A. -Under Miscellaneous Provisions 1. Insurance Liability and Release, read, "the resident agrees that [licensee] will not be liable to the resident for any personal injury or property damage." On May 5, 2025, at 1:13 p.m., LALD-A stated liability waiver language would be removed from the licensee's contract. LALD-A stated a new contract would be developed and implemented for any resident. No further information provided.	{0 970}		
01330 SS=F	144G.60 Subd. 4 (b) Unlicensed personnel (b) Unlicensed personnel performing delegated	01330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	R 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
01330	Continued From page 20 nursing tasks in an assisted living facility must: (1) have successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform; (2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or 484.36; or (3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a licensed registered nurse (RN) provided training and completed competency evaluations for all required skill areas, prior to providing services, for one of three 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 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:	01330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	R 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
01330	Continued From page 21 On March 15, 2024, a change of ownership (CHOW) was completed transferring ownership from previous licensee to current licensee. R1 was admitted on February 7, 2020, with diagnosis including, dementia, incontinence, aphasia, and history of breast cancer. R1's Service Plan dated February 8, 2024, indicated R1 required activities of daily living (ADLs), medication, and treatment management services. R1's Initial Assessment dated February 11, 2024, completed by clinical nurse supervisor (CNS)-C indicated R1 required total assistance with all ADLs, medications to be administered via G-tube (gastrostomy tube, a tube inserted through the abdomen into the stomach for the delivery of medications or nutrition/hydration), and ostomy care to G-tube site. R1's Task Administration Record dated April 2025, indicated ULP-C provided R1 delegated services for medication management, treatment management, and ADLs. CNS-D was hired by the previous licensee on February 8, 2024. CNS-D's RN license was issued on March 19, 1991, and expired on July 31, 2024. ULP-C was hired on September 25, 2024. ULP-C's record lacked evidence ULP-C was trained, found competent, and delegated nursing services by a licensed RN. The licensee's survey completed on December 6,	01330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	R 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
01330	Continued From page 22 2024, included an immediate order (IO, an order requiring the immediate attention of the licensee to remedy the citation due to the risk of harm to a resident) as licensee was operating without a licensed RN due to CNS-D's expired license. The licensee identified CNS-M as a replacement RN to address the IO and remedy the situation. CNS-M was hired by licensee on December 3, 2024, to remedy the IO. On May 7, 2025, at 12:01 a.m., an email from CNS-M indicated CNS-M did not provide any training, competency testing, or delegate nursing task to any ULP who was employed by the licensee. The email read, "[CNS-M] joined the facility in December 2024 as a backup RN and was confident that the staff had completed all necessary training and competency evaluations at the time of their hire." On May 7, 2025, at 10:30 a.m., owner/assistant administrator (O/AA)-I stated licensee's previous CNS-D should have renewed their license and provided training to the employees and when that did not occur, CNS-M should have reviewed each employee's record to ensure all training, competency, and delegation of nursing services was completed and documented as required. The licensee's Delegation of Assisted Living Tasks, Staff Competency, and Staff Orientation and Education policies all dated January 24, 2022, each indicated a licensed RN would be responsible for providing and evaluating training for all staff. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7)	01330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	R 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
01330	Continued From page 23 days	01330		
{01360} SS=F	144G.61 Subdivision 1 Instructor and competency evaluation requirem Instructors and competency evaluators must meet the following requirements: (1) training and competency evaluations of unlicensed personnel who only provide assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), must be conducted by individuals with work experience and training in providing these services; and (2) training and competency evaluations of unlicensed personnel providing assisted living services must be conducted by a registered nurse, or another instructor may provide training in conjunction with the registered nurse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a licensed registered nurse (RN) provided training and competency evaluations of unlicensed personnel (ULP) providing assisted living services for one of three 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) 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:	{01360}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	R 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
{01360}	Continued From page 24 On March 15, 2024, a change of ownership (CHOW) was completed transferring ownership from previous licensee to current licensee. CNS-D was hired by the previous licensee on February 8, 2024. CNS-D's RN license was issued on March 19, 1991, and expired on July 31, 2024. ULP-C was hired on September 25, 2024. ULP-C's record lacked evidence ULP-C was trained, found competent, and delegated nursing services by a licensed RN. The licensee's survey completed on December 6, 2024, included an immediate order (IO, an order requiring the immediate attention of the licensee to remedy the citation due to the risk of harm to a resident) as licensee was operating without a licensed RN due to CNS-D's expired license. The licensee identified CNS-M as a replacement RN to address the IO and remedy the situation. CNS-M was hired by licensee on December 3, 2024, to remedy the IO. On May 5, 2025, at 10:10 a.m., during a phone call, CNS-M was identified by licensed assisted living director (LALD)-A as only RN employed by licensee. On May 7, 2025, at 12:01 a.m., an email from CNS-M indicated CNS-M did not provide any training, competency testing, or delegate nursing task to any ULP who was employed by the licensee. The email read, "[CNS-M] joined the facility in December 2024 as a backup RN and was confident that the staff had completed all	{01360}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	R 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
{01360}	Continued From page 25 necessary training and competency evaluations at the time of their hire." On May 7, 2025, at 10:30 a.m., owner/assistant administrator (O/AA)-I stated licensee's previous CNS-D should have renewed their license and provided training to the employees and when that did not occur, CNS-M should have reviewed each employee's record to ensure all training, competency, and delegation of nursing services was completed and documented as required. The licensee's Delegation of Assisted Living Tasks, Staff Competency, and Staff Orientation and Education policies all dated January 24, 2022, each indicated a licensed RN would be responsible for providing and evaluating training for all staff. No further information provided.	{01360}		
{01390} SS=F	144G.62 Subdivision 1 Availability of contact person to staff (a) Assisted living facilities must have a registered nurse available for consultation by staff performing delegated nursing tasks and must have an appropriate licensed health professional available if performing other delegated services such as therapies. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a licensed registered nurse (RN) conducted training and competency evaluations with delegated nursing tasks for one of three unlicensed personnel (ULP)-C.	{01390}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	R 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
{01390}	Continued From page 26 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: On March 15, 2024, a change of ownership (CHOW) was completed transferring ownership from previous licensee to current licensee. R1 was admitted on February 7, 2020, with diagnoses including dementia, incontinence, aphasia, and history of breast cancer. R1's Service Plan dated February 8, 2024, indicated R1 required activities of daily living (ADLs), medication, and treatment management services. R1's Initial Assessment dated February 11, 2024, completed by clinical nurse supervisor (CNS)-C indicated R1 required total assistance with all ADLs, medications to be administered via G-tube (gastrostomy tube, a tube inserted through the abdomen into the stomach for the delivery of medications or nutrition/hydration), and ostomy care to G-tube site. R1's Task Administration Record dated April 2025, indicated ULP-C provided R1 delegated services for medication management, treatment management, and ADLs. CNS-D was hired by the previous licensee on	{01390}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	R 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
{01390}	Continued From page 27 February 8, 2024. CNS-D's RN license was issued on March 19, 1991, and expired on July 31, 2024. ULP-C was hired on September 25, 2024. ULP-C's record lacked evidence ULP-C was trained, found competent, and delegated nursing tasks by a licensed RN. The licensee's survey completed on December 6, 2024, included an immediate order (IO, an order requiring the immediate attention of the licensee to remedy the citation due to the risk of harm to a resident) as licensee was operating without a licensed RN due to CNS-D's expired license. The licensee identified CNS-M as a replacement RN to address the IO and remedy the situation. CNS-M was hired by licensee on December 3, 2024, to remedy the IO. On May 7, 2025, at 12:01 a.m., an email from CNS-M indicated CNS-M did not provide any training, competency testing, or delegate nursing task to any ULP who was employed by the licensee. The email read, "[CNS-M] joined the facility in December 2024 as a backup RN and was confident that the staff had completed all necessary training and competency evaluations at the time of their hire." On May 7, 2025, at 10:30 a.m., owner/assistant administrator (O/AA)-I stated licensee's previous CNS-D should have renewed their license and provided training to the employees and when that did not occur, CNS-M should have reviewed each employee's record to ensure all training, competency, and delegation of nursing services	{01390}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	R 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
{01390}	Continued From page 28 was completed and documented as required. The licensee's Delegation of Assisted Living Tasks policy dated January 24, 2022, indicated a RN was responsible for the training in the proper methods to perform delegated assisted living nursing tasks. No further information provided.	{01390}		
{01420} SS=F	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If the unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a licensed registered nurse (RN) conducted training and competency evaluations with delegated nursing tasks for one of three unlicensed personnel (ULP)-C. This practice resulted in a level two violation (a	{01420}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	R 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
{01420}	Continued From page 29 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: On March 15, 2024, a change of ownership (CHOW) was completed transferring ownership from previous licensee to current licensee. R1 was admitted on February 7, 2020, with diagnoses including dementia, incontinence, aphasia, and history of breast cancer. R1's Service Plan dated February 8, 2024, indicated R1 required activities of daily living (ADLs), medication, and treatment management services. R1's Initial Assessment dated February 11, 2024, completed by clinical nurse supervisor (CNS)-C indicated R1 required total assistance with all ADLs, medications to be administered via G-tube (gastrostomy tube, a tube inserted through the abdomen into the stomach for the delivery of medications or nutrition/hydration), and ostomy care to G-tube site. R1's Task Administration Record dated April 2025, indicated ULP-C provided R1 delegated services for medication management, treatment management, and ADLs. CNS-D was hired by the previous licensee on February 8, 2024.	{01420}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	R 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
{01420}	Continued From page 30 CNS-D's RN license was issued on March 19, 1991, and expired on July 31, 2024. ULP-C was hired on September 25, 2024. ULP-C's record lacked evidence ULP-C was trained, found competent, and delegated nursing tasks by a licensed RN. The licensee's survey completed on December 6, 2024, included an immediate order (IO, an order requiring the immediate attention of the licensee to remedy the citation due to the risk of harm to a resident) as licensee was operating without a licensed RN due to CNS-D's expired license. The licensee identified CNS-M as a replacement RN to address the IO and remedy the situation. CNS-M was hired by licensee on December 3, 2024, to remedy the IO. On May 7, 2025, at 12:01 a.m., an email from CNS-M indicated CNS-M did not provide any training, competency testing, or delegate nursing task to any ULP who was employed by the licensee. The email read, "[CNS-M] joined the facility in December 2024 as a backup RN and was confident that the staff had completed all necessary training and competency evaluations at the time of their hire." On May 7, 2025, at 10:30 a.m., owner/assistant administrator (O/AA)-I stated licensee's previous CNS-D should have renewed their license and provided training to the employees and when that did not occur, CNS-M should have reviewed each employee's record to ensure all training, competency, and delegation of nursing services was completed and documented as required.	{01420}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	R 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
{01420}	Continued From page 31 The licensee's Delegation of Assisted Living Tasks policy dated January 24, 2022, indicated a RN was responsible for the training in the proper methods to perform delegated assisted living nursing tasks. No further information provided.	{01420}		
01440 SS=F	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 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 interview and record review, the	01440		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	R 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
01440	Continued From page 32 licensee failed to ensure one of three unlicensed personnel ((ULP)-C) were supervised within 30 days of being trained for a delegated a nursing tasks by a licensed registered nurse (RN). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On March 15, 2024, a change of ownership (CHOW) was completed transferring ownership from previous licensee to current licensee. R1 was admitted on February 7, 2020, with diagnoses including dementia, incontinence, aphasia, and history of breast cancer. R1's Service Plan dated February 8, 2024, indicated R1 required activities of daily living (ADLs), medication, and treatment management services. R1's Initial Assessment dated February 11, 2024, completed by clinical nurse supervisor (CNS)-C indicated R1 required total assistance with all ADLs, medications to be administered via G-tube (gastrostomy tube, a tube inserted through the abdomen into the stomach for the delivery of medications or nutrition/hydration), and ostomy care to G-tube site. R1's Task Administration Record dated April	01440		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	R 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
01440	Continued From page 33 2025, indicated ULP-C provided R1 delegated services for medication management, treatment management, and ADLs. CNS-D was hired by the previous licensee on February 8, 2024. CNS-D's RN license was issued on March 19, 1991, and expired on July 31, 2024. ULP-C was hired on September 25, 2024. ULP-C's record lacked evidence ULP-C was trained, found competent, delegated nursing tasks, and supervised within 30 days by a licensed RN. The licensee's survey completed on December 6, 2024, included an immediate order (IO, an order requiring the immediate attention of the licensee to remedy the citation due to the risk of harm to a resident) as licensee was operating without a licensed RN due to CNS-D's expired license. The licensee identified CNS-M as a replacement RN to address the IO and remedy the situation. CNS-M was hired by licensee on December 3, 2024, to remedy the IO. On May 7, 2025, at 12:01 a.m., an email from CNS-M indicated CNS-M did not provide any training, competency testing, or delegate nursing task to any ULP who was employed by the licensee. The email read, "[CNS-M] joined the facility in December 2024 as a backup RN and was confident that the staff had completed all necessary training and competency evaluations at the time of their hire." On May 7, 2025, at 10:30 a.m., owner/assistant	01440		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	R 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
01440	Continued From page 34 administrator (O/AA)-I stated licensee's previous CNS-D should have renewed their license and provided training to the employees and when that did not occur, CNS-M should have reviewed each employee's record to ensure all training, competency, and delegation of nursing services was completed and documented as required. The licensee's Staff Competency policy dated January 24, 2022, indicated a RN would be responsible for supervision and documentation of supervision on each employee's record. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
{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	{01620}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	R 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
{01620}	Continued From page 35 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 a licensed registered nurse (RN) conducted ongoing resident monitoring and reassessment not to exceed 90 calendar days from the last date of assessment and failed to complete an assessment when a resident had a change of condition (CoC) for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 May 5, 2025, at 10:40 a.m., surveyor noted a person exit licensee's facility and identified themselves as registered nurse (RN)-L for Palliative Care Nurse Case Manager for a local home care company. RN-L stated that they were present to complete wound care services for R1 who was recently admitted to palliative care (specialized care with a goal of quality-of-life improvement when a person has a serious chronic illness). RN-L stated that R1 had been on hospice care but had a change of condition and	{01620}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	R 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
{01620}	Continued From page 36 was transitioned to palliative care a couple week prior. RN-L stated they had not had contact from a RN employed by the licensee since R1's transition to palliative care. R1 was admitted on February 7, 2020, with diagnoses including dementia, incontinence, aphasia, and history of breast cancer. R1's Service Plan dated February 8, 2024, indicated R1 required activities of daily living (ADLs), medication, treatment management services, and assessments would be completed upon admission and within 14-days, but no additional assessments would be completed. R1's Initial Assessment dated February 11, 2024, completed by clinical nurse supervisor (CNS)-C was indicated by licensed assisted living director (LALD)-A as R1's most recent assessment. A total of 449 days had passed since R1's previous assessment. The screen shot of R1's Assessments On File electronic health record (EHR) dated May 5, 2025, at 1:18 p.m., listed all assessments licensee had completed in R1's record and indicated February 11, 2024, as the last assessment completed by a registered nurse. On May 7, 2025, at 12:01 a.m., an email from CNS-M read, "Regarding resident records, I encountered some challenges navigating the ECP electronic charting system due to my limited familiarity. When hospice took over care, I wasn't certain whether additional assessments were required since the resident's status remained unchanged. However, I understand the importance of thorough documentation," and "Given my relatively short time at the facility (less	{01620}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	R 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
{01620}	Continued From page 37 than a year), I'm unsure if I should have completed the annual medication and treatment management assessment. Thank you for bringing this to my attention. I will verify staff training and competency documentation, resident assessments, and complete necessary assessments for delegated tasks." The licensee's Assessment and Reassessment policy dated January 24, 2022, indicated assessments would be completed no greater than 90 days from the previous assessment and when a resident had a change of condition or service needs. No further information provided.	{01620}		
{01640} SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees	{01640}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	R 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
{01640}	Continued From page 38 when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure resident's service plans were authenticated by the resident or resident's representative for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: R1 was admitted on February 7, 2020, with diagnoses including dementia, incontinence, aphasia, and history of breast cancer. R1's Service Plan dated February 8, 2024, was authenticated by clinical nurse supervisor (CNS)-D but lacked evidence the service plan was provided to and authenticated by R1 or R1's designated representative. On May 5, 2025, at 1:40 p.m., licensed assisted living director (LALD)-A stated R1's service plan was completed by licensee's previous CNS and was not sure why R1 or R1's designated representative authentication was not included. LALD-A stated a new service plan would need to be created by current CNS-M and provided to	{01640}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	R 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
{01640}	Continued From page 39 R1's designated representative for authentication. The licensee's Service Plan policy dated January 24, 2022, indicated service plans and any revisions would be authenticated by the resident or resident's representative to agree on services to be provided. No further information provided.	{01640}		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	R 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
01650	Continued From page 40 declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure resident's service plans included all required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: R1 was admitted on February 7, 2020, with diagnoses including dementia, incontinence, aphasia, and history of breast cancer. R1's Service Plan dated February 8, 2024, was authenticated by clinical nurse supervisor (CNS)-D and lacked the following: - Fees for services; - Frequency of each service; - Identification of the staff who would provide services; and - Schedule and method of monitoring staff who provided services as no check marks noted in the area of the services plan. On May 5, 2025, at 1:40 p.m., licensed assisted living director (LALD)-A stated R1's service plan was completed by licensee's previous CNS and	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	R 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
01650	Continued From page 41 was not sure why the previous CNS did not complete all required content. LALD-A stated a new service plan would need to be created by current CNS-M based on CNS-M's assessment of services for R1. The licensee's Service Plan policy dated January 24, 2022, indicated service plans would include all required content based on the assessment of a registered nurse. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01710 SS=F	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) completed a face-to-face individualized medication management plan (IMMP) annual reassessment for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	01710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	R 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
01710	Continued From page 42 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: R1 was admitted on February 7, 2020, with diagnoses including dementia, incontinence, aphasia, and history of breast cancer. R1's Service Plan dated February 8, 2024, indicated R1 required activities of daily living (ADLs), medication, and treatment management services. R1's Initial Assessment dated February 11, 2024, completed by clinical nurse supervisor (CNS)-D was indicated by licensed assisted living director (LALD)-A as R1's most recent assessment. A total of 449 days had passed since R1's previous assessment. The assessment included R1's most recent IMMP review. CNS-M was hired by licensee on December 3, 2024. On May 7, 2025, at 12:01 a.m., an email from CNS-M read, "Regarding resident records, I encountered some challenges navigating the ECP electronic charting system due to my limited familiarity. When hospice took over care, I wasn't certain whether additional assessments were required since the resident's status remained unchanged. However, I understand the importance of thorough documentation," and "Given my relatively short time at the facility (less than a year), I'm unsure if I should have completed the annual medication and treatment management assessment. Thank you for bringing	01710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	R 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
01710	Continued From page 43 this to my attention. I will verify staff training and competency documentation, resident assessments, and complete necessary assessments for delegated tasks." The licensee's Assessment of Medications policy dated January 24, 2022, indicated medication management services assessments would be conducted at a minimum annually. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	R 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
01730	Continued From page 44 tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and maintain a current individualized medication management record to include all required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), 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: R1 was admitted on February 7, 2020, with	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	R 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
01730	Continued From page 45 diagnoses including dementia, incontinence, aphasia, and history of breast cancer. R1's Service Plan dated February 8, 2024, indicated R1 required activities of daily living (ADLs), medication and treatment management services. R1's Medication Management Plan included with R1's Service Plan dated February 8, 2024, lacked a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions. CNS-M was hired by licensee on December 3, 2024. On May 7, 2025, at 12:01 a.m., an email from CNS-M read, "Regarding resident records, I encountered some challenges navigating the ECP electronic charting system due to my limited familiarity. When hospice took over care, I wasn't certain whether additional assessments were required since the resident's status remained unchanged. However, I understand the importance of thorough documentation," and "Given my relatively short time at the facility (less than a year), I'm unsure if I should have completed the annual medication and treatment management assessment. Thank you for bringing this to my attention. I will verify staff training and competency documentation, resident assessments, and complete necessary assessments for delegated tasks." The licensee's Service Plan for Medication Management policy dated January 24, 2022, indicated each resident's medication management plan would include a description of	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	R 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
01730	Continued From page 46 the storage of mediations. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01730		
{01750} SS=I	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure one of three unlicensed personnel (ULP-C) had been trained and competency tested by a licensed registered nurse (RN) prior to administering medications. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large	{01750}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	R 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
{01750}	Continued From page 47 portion or all of the residents). The findings include: On March 15, 2024, a change of ownership (CHOW) was completed transferring ownership from previous licensee to current licensee. R1 was admitted on February 7, 2020, with diagnoses including dementia, incontinence, aphasia, and history of breast cancer. R1's Service Plan dated February 8, 2024, indicated R1 required activities of daily living (ADLs), medication, and treatment management services. R1's Initial Assessment dated February 11, 2024, completed by clinical nurse supervisor (CNS)-C indicated R1 required total assistance with all ADLs, medications to be administered via G-tube (gastrostomy tube, a tube inserted through the abdomen into the stomach for the delivery of medications or nutrition/hydration), and ostomy care to G-tube site. R1's Medication Administration Record (MAR) dated April 2025, indicated ULP-C administered R1's medications on 13 of 30 days in April. CNS-D was hired by the previous licensee on February 8, 2024. CNS-D's RN license was issued on March 19, 1991, and expired on July 31, 2024. ULP-C was hired on September 25, 2024. ULP-C's record lacked evidence ULP-C was trained, found competent, and delegated	{01750}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	R 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
{01750}	Continued From page 48 mediation administration tasks by a licensed RN. The licensee's survey completed on December 6, 2024, included an immediate order (IO, an order requiring the immediate attention of the licensee to remedy the citation due to the risk of harm to a resident) as licensee was operating without a licensed RN due to CNS-D's expired license. The licensee identified CNS-M as a replacement RN to address the IO and remedy the situation. CNS-M was hired by licensee on December 3, 2024, to remedy the IO. On May 7, 2025, at 12:01 a.m., an email from CNS-M indicated CNS-M did not provide any training, competency testing, or delegate medication administration tasks to any ULP who was employed by the licensee. The email read, "[CNS-M] joined the facility in December 2024 as a backup RN and was confident that the staff had completed all necessary training and competency evaluations at the time of their hire." On May 7, 2025, at 10:30 a.m., owner/assistant administrator (O/AA)-I stated licensee's previous CNS-D should have renewed their license and provided training to the employees and when that did not occur, CNS-M should have reviewed each employee's record to ensure all training, competency, and delegation of nursing services was completed and documented as required. The licensee's Delegation of Assisted Living Tasks policy dated January 24, 2022, indicated a RN was responsible for the training in the proper methods to perform delegated assisted living nursing tasks. No further information was provided.	{01750}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	R 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
{01760} SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure medication administration was documented accurately for one of one resident (R1) who did not receive medications as prescribed. 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: R1 was admitted on February 7, 2020, with diagnoses including dementia, incontinence, aphasia, and history of breast cancer.	{01760}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	R 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
{01760}	Continued From page 50 R1's Service Plan dated February 8, 2024, indicated R1 required activities of daily living (ADLs), medication, and treatment management services. R1's Initial Assessment dated February 11, 2024, completed by clinical nurse supervisor (CNS)-C indicated R1 required total assistance with all ADLs, medications to be administered via G-tube (gastrostomy tube, a tube inserted through the abdomen into the stomach for the delivery of medications or nutrition/hydration), and ostomy care to G-tube site. R1's Medication Administration Record (MAR) dated April 2025, included an order for Polyethylene Glycol 3350 (a common over-the-counter medication used to relieve constipation) mix 8.5 GM (gram) (1 capful) in 6 oz (ounces) of liquid and give per G-tube every day. The medication was documented as completely given every day in April. R1's MAR dated April 2025, included a section titled Scheduled Mediations Notations and indicated R1 received a ½ (half) capful of Polyethylene Glycol 3350 a total of eight (8) times in April. No additional notations were made as to the reason only ½ capful was administered, if the nurse was contacted, and actions taken when R1 did not receive the full dose as ordered. On May 7, 2025, at 12:01 a.m., an email from CNS-M read, "Regarding resident records, I encountered some challenges navigating the ECP electronic charting system due to my limited familiarity. When hospice took over care, I wasn't certain whether additional assessments were required since the resident's status remained	{01760}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	R 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
{01760}	Continued From page 51 unchanged. However, I understand the importance of thorough documentation," and "Given my relatively short time at the facility (less than a year), I'm unsure if I should have completed the annual medication and treatment management assessment. Thank you for bringing this to my attention. I will verify staff training and competency documentation, resident assessments, and complete necessary assessments for delegated tasks." On May 7, 2025, at 10:30 a.m., owner/assistant administrator (O/AA)-I stated they were not sure why R1 was not administered the full dose as ordered. O/AA-I stated CNS-M should have reviewed the documentation and the staff who only administered a ½ capful should have contacted the nurse for directions. O/AA-I stated CNS-M would need to complete a medication assessment on R1 and train the staff on the proper procedures for partial administration of mediations. The licensee's Medication Documentation policy dated January 24, 2022, indicated if medication administration was not completed, documentation on reason, follow up, and notifications to the nurse would be completed. No further information was provided.	{01760}		
01820 SS=F	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident.	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	R 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
01820	Continued From page 52 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R1 was admitted on February 7, 2020, with diagnoses including dementia, incontinence, aphasia, and history of breast cancer. R1's Service Plan dated February 8, 2024, indicated R1 required activities of daily living (ADLs), medication, and treatment management services. R1's Initial Assessment dated February 11, 2024, completed by clinical nurse supervisor (CNS)-C indicated R1 required total assistance with all ADLs, medications to be administered via G-tube (gastrostomy tube, a tube inserted through the abdomen into the stomach for the delivery of medications or nutrition/hydration), and ostomy care to G-tube site. R1's Medication Administration Record (MAR) dated April 2025, indicated R1 had thirty (30) unique medication orders, with thirteen (13) medications being scheduled to be administered	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	R 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
01820	Continued From page 53 daily. R1's record lacked any authenticated provider's orders for any medications the licensee had provided to R1. On May 7, 2025, at 12:01 a.m., an email from CNS-M read, "Regarding resident records, I encountered some challenges navigating the ECP electronic charting system due to my limited familiarity. When hospice took over care, I wasn't certain whether additional assessments were required since the resident's status remained unchanged. However, I understand the importance of thorough documentation," and "Given my relatively short time at the facility (less than a year), I'm unsure if I should have completed the annual medication and treatment management assessment. Thank you for bringing this to my attention. I will verify staff training and competency documentation, resident assessments, and complete necessary assessments for delegated tasks." On May 7, 2025, at 10:30 a.m., owner/assistant administrator (O/AA)-I stated they were not sure why R1's record lacked authenticated orders. O/AA-I stated CNS-M would need to contact R1 provider and obtained all authenticated orders for the medications and treatments the licensee provided to R1. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
{01880} SS=F	144G.71 Subd. 19 Storage of medications	{01880}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	R 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
{01880}	Continued From page 54 An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were stored securely for one of one resident (R1) with medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On May 5, 2025, at 10:50 a.m., during a tour of the facility, a room was noted next to R1's bedroom which included a medication cart. Unlicensed personnel (ULP)-C was the only staff member present in the facility. While ULP-C was providing cares to R1, surveyor entered the room with the medication cart. On top of the medication cart was a set of keys. The medication cart was unsecured, and all drawers opened. One drawer included a locked top and the keys on top of the medication cart were able to open the locked compartment where controlled medications were stored. The surveyor returned all items, including the keys, back to their original locations and left the room.	{01880}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	R 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
{01880}	Continued From page 55 R1 was admitted on February 7, 2020, with diagnoses including dementia, incontinence, aphasia, and history of breast cancer. R1's Service Plan dated February 8, 2024, indicated R1 required activities of daily living (ADLs), medication, and treatment management services. R1's Medication Management Plan included with R1's Service Plan dated February 8, 2024, lacked a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions. On May 7, 2025, at 12:01 a.m., an email from CNS-M read, "Regarding resident records, I encountered some challenges navigating the ECP electronic charting system due to my limited familiarity. When hospice took over care, I wasn't certain whether additional assessments were required since the resident's status remained unchanged. However, I understand the importance of thorough documentation," and "Given my relatively short time at the facility (less than a year), I'm unsure if I should have completed the annual medication and treatment management assessment. Thank you for bringing this to my attention. I will verify staff training and competency documentation, resident assessments, and complete necessary assessments for delegated tasks." On May 7, 2025, at 10:30 a.m., owner/assistant administrator (O/AA)-I stated they were not sure why ULP-C left the medication cart unsecured and with the keys out for anyone to access. O/AA-I stated all staff had been trained to secure the medication cart and to keep the keys secured	{01880}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	R 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
{01880}	Continued From page 56 on their person when working. The licensee's partial Storage/Control of Medications policy dated January 24, 2022, indicated all prescription medications are securely stored, and only authorized nursing personnel would have access to the locked medication cart. No further information was provided.	{01880}		
{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	{01940}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	R 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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 57 possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to include a written statement of a treatment service on the resident's service plan for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R1 was admitted on February 7, 2020, with diagnoses including dementia, incontinence, aphasia, and history of breast cancer. R1's Service Plan dated February 8, 2024, indicated R1 required activities of daily living (ADLs), medication, and treatment management services. R1's Treatment Plan included with R1's Service Plan dated February 8, 2024, was blank and did not indicate R1 had a treatment plan service to be provided. R1's Initial Assessment dated February 11, 2024, completed by clinical nurse supervisor (CNS)-C indicated R1 required total assistance with all	{01940}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	R 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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 58 ADLs, medications to be administered via G-tube (gastrostomy tube, a tube inserted through the abdomen into the stomach for the delivery of medications or nutrition/hydration), and ostomy care to G-tube site. R1's Task Administration Record dated April 2025, indicated R1 had treatments including application and management of hand splints, G-tube site cleanings, and oxygen management scheduled to be completed daily. On May 7, 2025, at 12:01 a.m., an email from CNS-M read, "Regarding resident records, I encountered some challenges navigating the ECP electronic charting system due to my limited familiarity. When hospice took over care, I wasn't certain whether additional assessments were required since the resident's status remained unchanged. However, I understand the importance of thorough documentation," and "Given my relatively short time at the facility (less than a year), I'm unsure if I should have completed the annual medication and treatment management assessment. Thank you for bringing this to my attention. I will verify staff training and competency documentation, resident assessments, and complete necessary assessments for delegated tasks." On May 7, 2025, at 10:30 a.m., owner/assistant administrator (O/AA)-I stated they were not sure why R1's service plan lacked indication R1 had a treatment management plan. O/AA-I stated CNS-M would need to develop an updated service plan to include the treatment management plan content and obtain authentication from R1 or R1's designated representative.	{01940}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	R 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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 59 The licensee's Service Plan policy dated January 24, 2022, indicated each resident record would include all services provided by the licensee to a resident. No further information was provided.	{01940}		
{01950} SS=F	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure prior to delegating nursing tasks of prescribed treatment administration, a licensed registered nurse (RN) trained in the proper methods to perform the task or procedure for each resident and verified staff were able to demonstrate the ability to	{01950}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	R 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
{01950}	Continued From page 60 competently follow the procedure for one of one 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 15, 2024, a change of ownership (CHOW) was completed transferring ownership from previous licensee to current licensee. R1 was admitted on February 7, 2020, with diagnoses including dementia, incontinence, aphasia, and history of breast cancer. R1's Service Plan dated February 8, 2024, indicated R1 required activities of daily living (ADLs), medication, and treatment management services. R1's Initial Assessment dated February 11, 2024, completed by clinical nurse supervisor (CNS)-C indicated R1 required total assistance with all ADLs, medications to be administered via G-tube (gastrostomy tube, a tube inserted through the abdomen into the stomach for the delivery of medications or nutrition/hydration), and ostomy care to G-tube site. R1's Task Administration Record dated April 2025, indicated ULP-C provided R1 delegated services for medication management, treatment management, and ADLs.	{01950}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	R 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
{01950}	Continued From page 61 CNS-D was hired by the previous licensee on February 8, 2024. CNS-D's RN license was issued on March 19, 1991, and expired on July 31, 2024. ULP-C was hired on September 25, 2024. ULP-C's record lacked evidence ULP-C was trained, found competent, and delegated treatment nursing tasks by a licensed RN. The licensee's survey completed on December 6, 2024, included an immediate order (IO, an order requiring the immediate attention of the licensee to remedy the citation due to the risk of harm to a resident) as licensee was operating without a licensed RN due to CNS-D's expired license. The licensee identified CNS-M as a replacement RN to address the IO and remedy the situation. CNS-M was hired by licensee on December 3, 2024, to remedy the IO. On May 7, 2025, at 12:01 a.m., an email from CNS-M indicated CNS-M did not provide any training, competency testing, or delegate nursing task to any ULP who was employed by the licensee. The email read, "[CNS-M] joined the facility in December 2024 as a backup RN and was confident that the staff had completed all necessary training and competency evaluations at the time of their hire." On May 7, 2025, at 10:30 a.m., owner/assistant administrator (O/AA)-I stated licensee's previous CNS-D should have renewed their license and provided training to the employees and when that did not occur, CNS-M should have reviewed each	{01950}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	R 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
{01950}	Continued From page 62 employee's record to ensure all training, competency, and delegation of treatment nursing services was completed and documented as required. The licensee's Delegation of Assisted Living Tasks policy dated January 24, 2022, indicated a RN was responsible for the training in the proper methods to perform delegated assisted living nursing tasks. No further information provided.	{01950}		
{01970} SS=F	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure it had a physician order for one of one resident (R1) receiving treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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).	{01970}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	R 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
{01970}	Continued From page 63 The findings include: R1 was admitted on February 7, 2020, with diagnoses including dementia, incontinence, aphasia, and history of breast cancer. R1's Service Plan dated February 8, 2024, indicated R1 required activities of daily living (ADLs), medication, and treatment management services. R1's Initial Assessment dated February 11, 2024, completed by clinical nurse supervisor (CNS)-C indicated R1 required total assistance with all ADLs, medications to be administered via G-tube (gastrostomy tube, a tube inserted through the abdomen into the stomach for the delivery of medications or nutrition/hydration), and ostomy care to G-tube site. R1's Task Administration Record dated April 2025, indicated R1 had treatments including application and management of hand splints, G-tube site cleanings, and oxygen management being scheduled to be completed daily. R1's record lacked any authenticated provider's orders for any treatment the licensee had provided to R1. On May 7, 2025, at 12:01 a.m., an email from CNS-M read, "Regarding resident records, I encountered some challenges navigating the ECP electronic charting system due to my limited familiarity. When hospice took over care, I wasn't certain whether additional assessments were required since the resident's status remained unchanged. However, I understand the importance of thorough documentation," and	{01970}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	R 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
{01970}	Continued From page 64 "Given my relatively short time at the facility (less than a year), I'm unsure if I should have completed the annual medication and treatment management assessment. Thank you for bringing this to my attention. I will verify staff training and competency documentation, resident assessments, and complete necessary assessments for delegated tasks." On May 7, 2025, at 10:30 a.m., owner/assistant administrator (O/AA)-I stated they were not sure why R1's record lacked authenticated orders. O/AA-I stated CNS-M would need to contact R1's provider and obtained all authenticated orders for the medications and treatments the licensee provided to R1. The licensee's Prescriber's Orders policy dated January 24, 2022, indicated licensee would obtain prescriber's orders for all treatments licensee provided to a resident. No further information was provided.	{01970}		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 14, 2025

Licensee
Morning Star Healthcare Services
2925 Regent Avenue North
Crystal, MN 55422

RE: Project Number(s) SL29038016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 6, 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.

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

1390 - 144g.62 Subdivision 1 - Availability Of Contact Person To Staff - $3,000.00
2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $6,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
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.

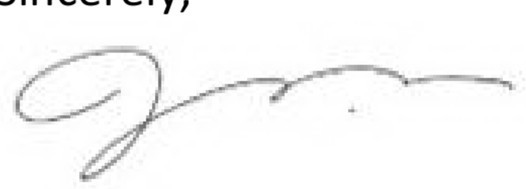
INFORMAL CONFERENCE
In accordance with Minn. Stat. § 144G.20, Subd. 20, the Commissioner of Health is authorized to hold a conference to exchange information, clarify issues, or resolve issues. The Department of Health staff would like to schedule a conference call with Morning Star Healthcare Services. Please contact Jess Schoenecker at 651-201-3789 on or before Wednesday, March 19, 2025, to schedule the conference call.

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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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: SL29038016-0 On December 2, 2024, through December 6, 2024, the Minnesota Department of Health conducted a change of ownership survey at the above provider. At the time of the survey, there was one resident; one receiving services under the Assisted Living Facility license. An immediate correction order was identified on December 2, 2024, issued for SL29038016-0, tag identification 1390. An immediate correction order was identified on December 3, 2024, issued for SL29038016-0, tag identification 2310. During the course of the survey, the licensee took action to mitigate the immediate risks. Noncompliance remained and the scopes and levels remain unchanged.	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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
0 250	Continued From page 1	0 250		
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or staff of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or staff; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
0 250	Continued From page 2 or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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:	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
0 250	Continued From page 3 During the entrance conference on December 2, 2024, at 11:23 a.m., licensed assisted living director (LALD)-A stated she was familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Provisional Assisted Living Licensure Information and Application, section titled "Official Verification of Owner or Authorized Agent", (page 17 of the application), identified "I certify I have read and understand the following:" - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G; - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659; - Reporting of Maltreatment of Vulnerable Adults; - Electronic Monitoring in Certain Facilities; - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets the requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police,	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
0 250	Continued From page 4 local or county public health offices; - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons, all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license; - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G and Minnesota Rules, chapter 4659, governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or contract; - I have examined this application and all attachments, and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and belief, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required; and - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659, in place upon licensure and to keep them current as applicable. Page 18 was electronically signed by owner/assistant administrator (O/AA)-I on January 5, 2024. The licensee had a provisional assisted living license issued on February 8, 2024, with an expiration date of February 2, 2025. The licensee failed to ensure the following	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
0 250	Continued From page 5 policies and procedures were developed and/or implemented: - requirements in section 626.557, reporting of maltreatment of vulnerable adults; - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - handling complaints regarding staff or services provided by staff; - conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; - conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United Stated Centers for Disease Control and Prevention standards; - ensuring that nurses and licensed health professionals have current and valid licenses to practice; - medication and treatment management; - delegation of tasks by registered nurses or licensed health professionals; and - supervision of unlicensed personnel performing delegated tasks. As a result of this survey, the following orders were issued under 0470, 0550, 0630, 0650, 0660, 0680, 0720, 0970, 1360, 1390, 1420, 1470, 1540, 1560, 1620, 1640, 1690, 1750, 1760, 1880, 1890, 1910, 1940, 1950, 1970, 2310, and 3090. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a staffing plan for determining the staffing level, that included an evaluation conducted at least twice a year of the appropriateness of staffing levels in the facility. The licensee also failed to ensure that two or	0 470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
0 470	Continued From page 7 more persons were available 24 hours per day, seven days per week, who were responsible for responding to the requests of residents for assistance with health or safety needs for one of one resident (R1) who required the assistance of two staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: During entrance conference on December 2, 2024, at 11:23 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-D stated they did not develop a staffing plan but could create one. They also stated they discussed the staffing need and determined they needed one staff person for each shift because they had one resident receiving services. The licensee's staff schedule dated November 1, 2024, through November 30, 2024, scheduled one staff person for each of the three shifts scheduled 7:00 a.m. to 3:00 p.m., 3:00 p.m. to 11:00 p.m., and 11:00 p.m. to 7:00 a.m. R1 was admitted to the facility February 8, 2024, and had diagnoses including early onset Alzheimer's disease, urinary incontinence, abnormalities of gait and mobility, and aphasia (loss of comprehension and language). R1's Service Plan dated February 8, 2024,	0 470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
0 470	Continued From page 8 indicated R1 received services including dressing and grooming, bathing, incontinence care, tube feeding, mobility, transfers using Hoyer (full body mechanical lift), and medication and treatment administration. R1's care plan printed December 4, 2024, indicated R1 needed assistance with transfers three times per day using a Hoyer lift. The care plan did not indicate number of staff required for the transfer. R1's Task Administration Record (TAR) dated November 1, 2024, through November 30, 2024, indicated staff documented their initials daily at 9:00 a.m., 4:00 p.m., and 10:00 p.m. (three of the time slots were left blank). On December 3, 2024, at 10:00 a.m., unlicensed personnel/house manager (ULP)-B stated R1 required assist of two staff with Hoyer for all transfers. ULP-B explained she was staffed as a second person during the week to assist with R1's Hoyer transfers. She stated R1 got out of bed about two or three times a week depending on staff availability. On December 3, 2024, at 2:13 p.m., on the main-level area of the single-level home, the surveyor observed R1's bedroom. The surveyor observed R1 in a hospital style bed with bilateral (both sides) bedrails. In the room was a Hoyer lift up against the window wall plugged in charging. On the Hoyer lift were the following identifying markings, "Medline, REF MDS450EL, Lot 83223110002." The surveyor also observed a manual wheelchair within the room. On December 4, 2024, at 12:49 p.m., the surveyor observed R1 come out of her room into	0 470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
0 470	Continued From page 9 the living room area in her wheelchair but was unable to observe the transfer using the Hoyer lift. On December 4, 2024, at 2:02 p.m., CNS-D stated she determined two staff were required to use the Hoyer based on her online training and had trained all staff to use two staff for every transfer. The licensee's Staffing policy dated January 24, 2022, indicated licensee's clinical nurse supervisor would prepare and implement a 24-hour daily staffing plan that ensures adequate staffing to meeting residents needs at all times, including reasonably foreseeable needs. Assisted Living Facilities: Minnesota Rules Chapter 4659.0180 Subpart 5., indicates, "A minimum of two direct-care staff must be scheduled and available to assist at all times whenever a resident requires the assistance of two direct-care staff for scheduled reasonably foreseeable and unscheduled needs, as reflected in the resident's assessments and service plan." No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 470		
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.	0 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
0 550	Continued From page 10 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 failed to post in a conspicuous place, information about the facility's grievance procedure with the required content. This had the potential to affect the licensee's current resident, 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: During facility tour on December 2, 2024, at 10:45 a.m., with licensed assisted living director (LALD)-A and unlicensed personnel/house manager (ULP)-B, the surveyor was unable to locate the grievance procedure with the required content.	0 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
0 550	Continued From page 11 On December 3, 2024, at 11:10 a.m., LALD-A stated the grievance procedure was not posted and was not aware of that requirement. The licensee's Grievance policy dated January 24, 2022, indicated a copy of the grievance procedure would be conspicuously posted in the residence with the required content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include statements of the specific measures to be taken to minimize the risk of abuse for one of one resident (R1).	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
0 630	Continued From page 12 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: R1 had diagnoses including early onset Alzheimer's disease, urinary incontinence, abnormalities of gait and mobility, and aphasia (loss of comprehension and language). R1's Service Plan dated February 8, 2024, indicating R1 received services including dressing and grooming, bathing, incontinence care, tube feeding, mobility, transfers with full body mechanical lift, and medication and treatment administration. R1's Initial Assessment (nursing assessment) dated February 11, 2024, indicated R1 had some identified areas of potential vulnerability (self-abuse by unintentional scratching), but the record lacked an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults, and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. On December 6, 2024, at 11:02 a.m., clinical nurse supervisor (CNS)-D was unaware if there	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
0 630	Continued From page 13 was a document/assessment available to use but explained she discussed the risks with the staff saying R1 was high risk for abuse. CNS-D also explained R1 was not capable of abusing others due to her physical abilities but was not aware of the requirement. The licensee's Comprehensive Nursing Assessment policy dated January 24, 2022, indicated the registered nurse would conduct a comprehensive assessment for all residents admitted to licensee and the assessment would include a vulnerability assessment, including risk for elopement. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (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	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
0 650	Continued From page 14 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 observation, interview, and record review, the licensee failed to ensure employee records contained required content for three of three employees (unlicensed personnel/house manager (ULP)-B, unlicensed personnel (ULP)-C, and ULP-E). 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: ULP-B ULP-B was hired with the previous licensee on an unknown date and hired with current licensee on February 7, 2024. ULP-B was hired to provide direct care and services to the licensee's residents and assist with managerial duties. On December 3, 2024, at 1:55 p.m., ULP-B unlocked the medication cart, prepared R1's medications, locked the medication cart and administered medications through R1's	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
0 650	Continued From page 15 gastrostomy tube (opening in the stomach). ULP-B's employee record did not include a job description, review of the licensee's policies and procedures, and 30-day supervision performing delegated tasks by the registered nurse (RN). ULP-C ULP-C was hired on September 25, 2024, to provide direct care services to the licensee's residents. ULP-C's training record included online training completed between September 19-20, 2024, on the following topics: -aging process; -assisted living bill of rights; -client mobility-exercise, ambulation, lifting, safe transfers, positioning, and range of motion; and -customer service. ULP-C's employee record did not include a job description, remaining required orientation training, competencies, dementia training, and 30-day supervision performing delegated tasks by the RN. ULP-E ULP-E was hired on August 15, 2024, to provide direct care services to the licensee's residents. ULP-E's training record included online training completed between August 18-21, 2024, on the following topics: -aging process; -assisted living bill of rights; -dementia training (6.25 hours total); -emergency preparedness; -fall prevention; -personal cares; and	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
0 650	Continued From page 16 -person-centered care principles. ULP-E's employee record lacked a job description, remaining required orientation training, competencies, remaining dementia training, and 30-day supervision performing delegated tasks by the RN. During interview on December 2, 2024, at 1:37 p.m., clinical nurse supervisor (CNS)-D stated she would do a follow up observation about a week after training/competencies were completed by checking infection control practices and medication administration. She was unsure where she documented the observations (they were never provided to the surveyor). CNS-D stated she did not determine if all staff were competent to use the mechanical full body lift (Hoyer) because ULP-B was trained how to use the Hoyer by the prior licensee's RN. During interview on December 2, 2024, at 4:40 p.m., ULP-C stated she/he received training on wound care and medication administration by the RN, and received Hoyer and personal care training by ULP-B. During interview on December 4, 2024, at 2:55 p.m., ULP-E stated she started with licensee around August/September and worked at another assisted living facility unrelated to licensee. She received training by ULP-B and CNS-D. ULP-B trained her on the Hoyer and the nursed observed ULP-E use the Hoyer. For medications, she trained with ULP-B and CNS-D, and CNS-D did observe her administer medications. ULP-E stated she also completed some online training before she shadowed (training on the floor with another ULP).	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
0 650	Continued From page 17 During interview on December 5, 2024, at 11:20 a.m., licensed assisted living director (LALD)-A stated she was responsible for assigning the online courses for new hires and the courses should be completed prior to shadowing on the floor. She also explained staff did not understand how to complete all of the courses, so she was having a staff meting that Saturday to address the issue. LALD-A stated she gave all employees a job description including ULP-B for her house manager role. During interview on December 5, 2024, at 12:39 p.m., ULP-B stated she received her job description. The licensee's Personnel Records policy updated January 24, 2024, noted a record of each paid employee would include the following: documentation of orientation, documentation of supervision, competency evaluations, and a signed job description. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0190, Subp. 6, effective October 2022, the licensee must maintain a record of staff training and competency required under this part and Minnesota Statutes, chapter 144G, that documents the following information for each competency evaluation, training, retraining, and orientation topic: (1) facility name, location, and license number (2) name of the training topic or training program, and the training methodology, such as classroom style, web-based training, video, or one-to-one training (3) date of the training and competency evaluation, and the total amount of time of the training and competency evaluation (4) name and title of the instructor and the	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
0 650	Continued From page 18 instructor's signature, and the name and title of the competency evaluator, if different from the instructor, and the evaluator's signature with a statement attesting that the employee successfully completed the training and competency evaluation; and (5) name and title of the staff person completing the training, and the staff person's signature with statement attesting that the staff person successfully completed the training as described in the training documentation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
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:	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
0 660	Continued From page 19 Based on observation, interview, and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included: a follow-up on a positive Quantiferon-TB blood test and completion of TB history and symptom screening for two of two employees (unlicensed personnel (ULP)-C, ULP-E). In addition, the licensee lacked documentation a TB facility risk assessment was completed, as required. 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: On December 2, 2024, at 12:57 p.m., clinical nurse supervisor (CNS)-D stated she was somewhat familiar with what a facility risk assessment was, but said she did not have one available nor knew how often it needed to be completed. ULP-C On December 2, 2024, between 10:30 a.m., and 4:45 p.m., the surveyor observed ULP-C provide services to R1. ULP-C was hired on September 25, 2024, and provided direct care assisted living services to licensee's one resident.	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
0 660	Continued From page 20 ULP-C's employee record included a positive Quantiferon-TB Gold blood test, dated September 20, 2024. The record lacked documentation a history and symptom screening was completed. On December 3, 2024, at 11:38 a.m., licensed assisted living director (LALD)-A stated facility manager (FM)-K instructed ULP-C to complete a TB screen at the clinic. LALD-A stated she never received the results but was told by the nurse at the clinic the result was negative. She also stated she would work on getting a copy of the results. ULP-E On December 4, 2024, between 2:00 p.m., and 4:00 p.m., the surveyor observed ULP-E provide services to R1. ULP-E was hired on August 15, 2024, and provided direct care assisted living services to licensee's one resident. ULP-E's employee record included a positive Quantiferon-TB Gold blood test, dated August 24, 2024. The record lacked documentation a history and symptom screening was completed. On December 4, 2024, at 12:30 p.m., CNS-D stated owner/assistant administrator (O/AA)-I and FM-K were responsible for handling new hire TB screenings. CNS-D stated some people had received TB vaccines, so their tests were positive. CNS-D was unaware if staff had a positive TB gold test and what was done regarding the result. On December 4, 2024, at 1:46 p.m., LALD-A was unaware ULP-C and ULP-E's TB gold tests were positive. She explained that the clinic told FM-K	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
0 660	Continued From page 21 not to worry about the positive results and that they were cleared to work. The licensee's incomplete 4.14 Tuberculosis Screening/Prevention policy, dated 2022, indicated employees with a newly identified positive skin test or blood test: -assess for current TB symptoms and risk factors for progression to active TB disease -obtain a chest x-ray to exclude a diagnosis of active infectious TB disease before direct resident contact. Information related to completing a facility risk assessment was unavailable due to the incomplete policy. The Minnesota Department of Health (MDH) Facility Tuberculosis Risk Assessment Instructions and Worksheet for Health Care Settings Licensed by MDH, dated June 2024, indicated settings should perform a facility risk assessment on an annual basis. The U.S. Centers for Disease Control and Prevention (CDC) website under "Clinical Testing Guidance for Tuberculosis: Interferon Gamma Release Assay," dated May 9, 2024, indicated a person with a positive TB blood test result or symptoms of TB disease should be evaluated for TB disease. This includes performing: -a chest radiograph and -appropriate bacteriologic examinations of sputum specimens. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
0 680	Continued From page 22	0 680		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents receiving services under the assisted living license. Additionally, the licensee failed to post an emergency disaster plan prominently. This practice resulted in a level two violation (a	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
0 680	Continued From page 23 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: During facility tour on December 2, 2024, at 10:45 a.m., surveyor could not locate the EPP or a post indicating where the EPP could be found. On December 2, 2024, at 4:00 p.m., the surveyor asked unlicensed personnel (ULP)-C where the EPP could be found and after she looked around, she was unable to locate it. Clinical nurse supervisor (CNS)-D thought someone took the EPP out of the facility. On December 3, 2024, at 2:40 p.m., licensed assisted living director (LALD)-A brought the EPP into the facility along with the policies and procedures binder. LALD-A stated it was not in the facility because they were making modifications to it. The licensee's EPP lacked evidence of the following required content: -develop and maintain the EP: -hazard vulnerability assessment; -arrangements/contracts to re-establish utility services; -maintain and annual EP updates: -failure to review Missing Resident Plan quarterly and implement the plan; -process for EP collaboration: -process for cooperation/collaboration with	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
0 680	Continued From page 24 local, tribal, and regional EP; -development of EP policies and procedures; -subsistence needs for staff and patients: -address the following whether evacuated or shelter in place for staff/residents: -food, water, medical supplies, pharmaceutical supplies; -alternate sources of energy to maintain: -temperatures to protect resident health/safety; -safe/sanitary storage of provisions; -emergency lighting; -fire detection, extinguishing, alarm systems; and -sewage and waste disposal; -develop P/P (policies/procedures) to address system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records; -develop P/P that must address: use of volunteers, including the process/role for integration; -develop P/P to address role of facility under a waiver declared by the Secretary in accordance with section 1135 of the Act; -communication plan must include all the following names/contact information: staff, entities providing services under agreement, residents' physicians, other facilities, volunteers; -communication plan must include: primary and alternative means of communicating with: facility staff and Federal, State, tribal, regional & local emergency management agencies; -communication plan must include: method for sharing information and medical documentation for residents under the facility's care, as necessary with other health care providers (HCPs) to maintain continuity of care; -communication plan must include all of the following: means to providing information about the facility's occupancy needs, and it's ability to provide assistance, to the authority having	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
0 680	Continued From page 25 jurisdiction, the Incident Command Center, or designee; -communication plan must include all of the following: method for sharing information from the EP, that the facility has determined appropriate, with residents and their families/representatives; -must develop and maintain EP training and testing program: initial training in EP P/P to all new and existing staff, individuals providing services under arrangement, and volunteers consistent with their expected role, provide EP training at least annually and maintain documentation of all EP training; and -emergency prep testing requirements. During exit conference on December 6, 2024, at 3:38 p.m., LALD-A stated the EPP provided was their most updated version and was unaware it was missing the above required content. The licensee's Emergency Preparedness policy dated January 24, 2022, indicated the licensee would have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 720 SS=F	144G.43 Subd. 2 Access to records The facility must ensure that the appropriate records are readily available to employees and contractors authorized to access the records. Resident records must be maintained in a manner that allows for timely access, printing, or	0 720		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
0 720	Continued From page 26 transmission of the records. The records must be made readily available to the commissioner upon request. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure that resident records were readily available for timely access to employees, vendors, and the commissioner authorized to access the records. 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: RESIDENT RECORD R1 was admitted on February 8, 2024, and began receiving assisted living services. R1's Service Plan dated February 8, 2024, indicating R1 received services including dressing and grooming, bathing, incontinence care, tube feeding, mobility, transfers with full body mechanical lift, and medication and treatment administration. On December 3, 2024, at 12:31 p.m., the surveyor requested clinical nurse supervisor (CNS)-D additional nursing assessments because the initial assessment completed on February 11, 2024, was the only assessment	0 720		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
0 720	Continued From page 27 available in R1's record (both paper and electronic health record). CNS-D stated, "I could not find them, I did them on paper," and proceeded to search around for the assessments. On December 3, 2024, at 4:00 p.m., the surveyor again requested the nursing assessments, and CNS-D stated she would enter her paper assessments into R1's electronic health record. On December 4, 2024, at 3:30 p.m., the surveyor again requested R1's nursing assessments and CNS-D stated she was waiting for administrative access to the electronic health records to be able "to dig further to locate the assessments." The surveyor did not receive the requested nursing assessments for R1 prior to the completion of the survey. POLICY On December 3, 2024, at approximately 10:30 a.m., licensed assisted living director (LALD)-A provided the surveyor with a large white binder containing the licensee's policies and procedures. On December 4, 2024, at 2:20 p.m., via e-mail, the surveyor requested LALD-A to provide an entire Tuberculosis (TB) Screening/Prevention policy which had several pages missing from the beginning and end of the policy, including the entire procedure for handling persons with active TB disease. On December 5, 2024, at 11:20 a.m., the surveyor requested LALD-A in person, the full written or electronic TB policy. The surveyor did not receive the requested complete TB policy prior to the completion of the	0 720		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
0 720	Continued From page 28 survey. The licensee's Clinical Records policy dated January 24, 2022, noted clinical records would be maintained in such a manner that allows for timely access, printing or transmission of the records. The clinical record would include current and previous nursing assessments. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 720		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. 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	0 970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
0 970	Continued From page 29 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: R1's [name of licensee/facility] Assisted Living Contract signed February 8, 2024, included, on page seven of 15: Insurance Liability and Release: -"The resident shall maintain at all times his or her own health, personal property, liability, automobile (if applicable), and other insurance coverages and shall provide evidence of same by copies of binders or policies provided to [Licensee] upon request. The resident acknowledges that [Licensee] is not the insurer of the resident's person or property. The resident agrees that [Licensee] will not be liable to the resident for any personal injury or property damage (including, without limitation, damage to, or loss or theft of, automobiles or personal property of resident) suffered by the resident ...unless and to the extent that the injury or damage is caused by the negligence of [Licensee] or its employees or agents. The resident hereby releases [Licensee] from liability for any personal injury or property damage suffered by the resident ...unless caused by the negligence of [Licensee] or its employees or agents." On Page nine of 15: Indemnification: -"[Licensee] shall not be liable for any damage or injury to the resident, or any other person, or to any property, occurring on the premises, or any part thereof, or in common areas thereof, and the resident agrees to hold [Licensee] harmless from any claims or damages unless caused solely by negligence of [Licensee]. It is recommended that	0 970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
0 970	Continued From page 30 renter's insurance be purchased at the resident's expense. Nothing contained herein is intended to create a waiver of facility liability for the health and safety or personal property of a resident. On December 5, 2024, at 1:22 p.m., the licensee's contract was reviewed with owner/assistant administrator (O/AA)-I. O/AA-I did not believe the contract contained a waiver of liability because the insurance company limits what is covered but would reach out to the consultant for a new contract. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01360 SS=F	144G.61 Subdivision 1 Instructor and competency evaluation requirem Instructors and competency evaluators must meet the following requirements: (1) training and competency evaluations of unlicensed personnel who only provide assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), must be conducted by individuals with work experience and training in providing these services; and (2) training and competency evaluations of unlicensed personnel providing assisted living services must be conducted by a registered nurse, or another instructor may provide training in conjunction with the registered nurse. 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) provided training and competency evaluations of unlicensed personnel (ULP)	01360		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
01360	Continued From page 31 providing assisted living services for one of one employee (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) 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: During entrance conference on December 2, 2024, at 11:23 a.m., clinical nurse supervisor (CNS)-D explained she completed training on medication administration and nursing delegated tasks and unlicensed personnel/house manager (ULP)-B trained ULPs on personal cares by having them shadow and do a return demonstration. On December 2, 2024, between 10:30 a.m. and 4:45 p.m., the surveyor observed ULP-C provide services to R1. On December 2, 2024, at 1:37 p.m., CNS-D stated ULP-B completed Hoyer transfer training (full body mechanical lift) and personal cares with all staff because she was trained with the prior nurse before she (CNS-D) began employment with current licensee. CNS-D was not aware if ULP-B documented the training/competencies. CNS-D also stated ULP-B trained on gastrostomy (g-tube) site care. During interview on December 2, 2024, at 4:40 p.m., ULP-C stated she received wound care and medication administration training by CNS-D and	01360		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
01360	Continued From page 32 received Hoyer and personal cares training by ULP-B. During interview on December 4, 2024, at 2:02 p.m., CNS-D explained new staff observed ULP-B complete all tasks during the shift, then the next day, the new staff would assist with hands on care, and on the third day, ULP-B observed new staff complete all tasks on their own. CNS-D stated she tried to observe ULP-B complete the training with new staff but cannot spend the whole day (worked about five hours per week) but would spot check. ULP-C was hired on September 25, 2024, to provide services to licensee's residents. ULP-C's training record dated September 19, 2024 (before hire date), indicated ULP-C received online training on the following topics: -exercise and ambulation; -lifting and safe transfers; -positioning; -range of motion; and -customer service. ULP-C's record lacked remaining required trainings and documentation of competencies. The licensee's Staff Competency Training policy dated January 24, 2022, indicated ULP may not work for licensee until they have successfully passed the written and demonstration competency evaluation. The policy also indicated the CNS was responsible for the overall competency evaluation program. Education and competency testing for home health aides (ULP) providing comprehensive services will be administered by the registered nurse or other qualified instructor as delegated by the registered nurse.	01360		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
01360	Continued From page 33 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01360		
01390 SS=I	144G.62 Subdivision 1 Availability of contact person to staff (a) Assisted living facilities must have a registered nurse available for consultation by staff performing delegated nursing tasks and must have an appropriate licensed health professional available if performing other delegated services such as therapies. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN), who was providing services as the only RN employed by the licensee, was available for consultation by staff performing delegated nursing tasks and had a current Minnesota RN license or registration to practice, for one of one employee (clinical nurse supervisor (CNS)-D). The deficient practice had the potential to affect all residents and staff. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	01390	During the course of the survey, the licensee took action to mitigate the immediate risk. Noncompliance remained and the scope and level remain unchanged.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
01390	Continued From page 34 The findings include: During the entrance conference on December 2, 2023, at 11:23 a.m., CNS-D stated she was the only RN available and worked mostly at this facility, but there was a licensed practical nurse (LPN) who worked at another facility owned by the same owner. The licensee's Employee List dated December 2, 2024, indicated CNS-D was hired on February 8, 2024, to provide oversight of licensee's residents and training for unlicensed personnel (ULP) and was the only RN employed by the licensee. On December 2, 2024, at 3:56 p.m., the Minnesota (MN) Board of Nursing online licensure verification system indicated CNS-D's RN license expired on July 31, 2024. On December 2, 2024, at 3:58 p.m., CNS-D stated licensed assisted living director (LALD)-A informed CNS-D that her RN license expired in September. CNS-D stated she wasn't sure how she missed renewing her RN licensure, but it may have been because of multiple personal issues that occurred this year. CNS-D stated she was working on getting it renewed by completing 30 out of 48 hours of continuing education. On December 3, 2024, 10:35 a.m., LALD-A stated she was made aware CNS-D's RN licensure was expired a few months ago and since then had been working on a back-up RN to help cover. She said the back-up RN accepted the position last week. On December 3, 2024, at 10:56 a.m., unlicensed personnel and house manager (ULP)-B stated if she needed to contact a nurse for a question, she	01390		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
01390	Continued From page 35 would contact CNS-D. She stated there were no additional nurses to contact. Minnesota Statute 144G.41, subdivision 1, (13) dated 2024, indicated all assisted living facilities shall provide staff access to an on-call registered nurse 24 hours per day, seven days per week. Minnesota Statute 144G.60, subdivision 3, (a) dated 2024, indicated licensed health professionals and nurses providing services as staff members of a licensed facility must possess a current Minnesota license or registration to practice. A policy was requested but not available. No further information provided. TIME PERIOD FOR CORRECTION: Immediate	01390		
01420 SS=F	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If the unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions	01420		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
01420	Continued From page 36 for the delegated tasks in the resident's record. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) conducted training and competency evaluations for one of one unlicensed personnel (ULP)-C who utilized full body mechanical lift (Hoyer) transfers and gastronomy tube (g-tube) site care. 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: ULP-C was hired on September 25, 2024, to provide services to licensee's residents. On December 2, 2024, at 1:37 p.m., clinical nurse supervisor (CNS)-D stated unlicensed personnel/house manager (ULP)-B completed Hoyer transfer training and personal cares with all staff because she was trained with the prior nurse before she CNS-D began employment with current licensee. CNS-D was not aware if ULP-B documented the training/competencies. CNS-D also stated ULP-B trained on gastrostomy (g-tube) site care. During interview on December 2, 2024, at 4:40 p.m., ULP-C stated she received wound care and medication administration training by CNS-D and received Hoyer and personal cares training by	01420		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
01420	Continued From page 37 ULP-B. On December 3, 2024, at 1:55 p.m., ULP-B administered medications and nutrition formula through R1's g-tube. The surveyor observed the g-tube site to be clean, dry, and covered with gauze. While in R1's room, the surveyor observed R1's Hoyer against the window wall charging. R1's Task Administration Record (TAR) dated November 1, 2024, through November 30, 2024, indicated ULP-C performed the following tasks: -g-tube site care at 9:00 a.m., four (4) times and at 8:00 p.m., ten (10) times; and -hoyer transfers at 9:00 a.m., three (3) times, at 4:00 p.m., seven (7) times, and at 10:00 p.m., nine (9) times. ULP-C's employee record lacked documentation to indicate ULP-C was trained and demonstrated competency for using the Hoyer and g-tube site care. The licensee's Delegation of Assisted Living Tasks policy dated January 24, 2022, indicated when the registered nurse (RN) or licensed health professional is responsible for appropriately delegating tasks to staff who are competent and possess the knowledge and skills consistent with the complexity of the tasks. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01420		
01470 SS=F	144G.63 Subd. 2 Content of required orientation	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
01470	Continued From page 38 (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 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	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
01470	Continued From page 39 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 observation, interview, and record review, the licensee failed to ensure employees received all required assisted living orientation content for three of three employees (unlicensed personnel (ULP)-C, ULP-E, ULP-H). 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 included: ULP-C	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
01470	Continued From page 40 On December 2, 2024, between 10:30 a.m. and 4:45 p.m., the surveyor observed ULP-C work the shift by performing tasks such as laundry, cleaning, and cares. ULP-C was hired on September 25, 2024, to provide direct care services to the licensee's residents. ULP-C's training record included assisted living bill of rights training completed on September 19, 2024. ULP-E On December 4, 2024, between 2:00 p.m. and 4:00 p.m., the surveyor observed ULP-E provide services to R1. ULP-E was hired on August 15, 2024, to provide direct care services to the licensee's residents. ULP-E's training record included assisted living bill of rights completed on August 18, 2024, and person-centered care principles completed on August 21, 2024. ULP-H ULP-H was hired on October 15, 2024, to provide direct care services to the licensee's residents. ULP-H's training record included assisted living bill of rights training completed on December 4, 2024 (after the survey was initiated). ULP-C, ULP-E, and ULP-H's employee records did not contain documentation of completed required assisted living licensing and regulation orientation content before providing assisted living services to residents which included: - an overview of this chapter;	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
01470	Continued From page 41 - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; - handling of emergencies and use of emergency services; - compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); - principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person (this applies to ULP-C and ULP-H only); - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; - consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and -a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. On December 5, 2024, at 11:20 a.m., during phone interview, licensed assisted living director (LALD)-A stated she was responsible for assigning Educare courses (online training program) to all new hires, but if she could not assign them, she would have the owner/assistant administrator (O/AA)-I assign the courses. LALD-A stated the courses should be completed prior to shadowing (observation and hands on training) but stated staff do not understand how to complete all of the courses so she set up a staff	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
01470	Continued From page 42 meeting for upcoming Saturday to address the issue. On December 5, 2024, at 1:22 p.m., during phone interview, O/AA-I stated upon hire, he assigned the Educare courses but not all staff were completing them, and he stated he would take responsibility for ensuring staff complete the courses going forward. The licensee's Staff Orientation and Education policy dated January 24, 2022, indicated all employees must complete the orientation to assisted living facility requirements before providing assisted living services to residents. The orientation would include the following topics: - an overview of the appropriate Assisted Living statutes and rules; - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; - handling of emergencies and use of emergency services; - compliance with and reporting of the maltreatment of vulnerable adults under section 626.556 and 626.557; - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; - Grievance Policy/Process, including reports the Office of Health Facility Complaints; and - consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
01470	Continued From page 43 Services, county-managed care advocates, or other relevant advocacy services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
01540 SS=F	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 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 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 observation, interview, and record review, the licensee failed to ensure five of five employees (unlicensed personnel (ULP)-C, ULP-E, ULP-H, ULP-J, and clinical nurse supervisor (CNS)-D) received the required amount of dementia care training in the required time frame.	01540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
01540	Continued From page 44 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: R1 had diagnoses including early onset Alzheimer's disease, urinary incontinence, abnormalities of gait and mobility, and aphasia (loss of comprehension and language). During the survey on December 2, 2024, through December 3, 2024, at various times, the surveyor observed ULP-C, ULP-E, and CNS-D provided assisted living services to R1. ULP-C, ULP-E, ULP-H, ULP-J, and CNS-D were hired on September 25, 2024, August 15, 2024, October 15, 2024, May 8, 2024, and February 8, 2024, respectively. ULP-C and ULP-H's training records lacked dementia training. ULP-E, ULP-J, and CNS-D's training records included six hours and 15 minutes, five hours and 45 minutes, and seven hours and 15 minutes of dementia training, respectively. The licensee's staff schedule dated November 1, 2024, through November 30, 2024, scheduled one staff person for each of the three shifts scheduled 7:00 a.m. to 3:00 p.m., 3:00 p.m. to 11:00 p.m., and 11:00 p.m. to 7:00 a.m.	01540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
01540	Continued From page 45 During entrance conference on December 2, 2024, at 11:23 a.m., licensed assisted living director (LALD)-A and CNS-D stated they did not develop a staffing plan but could create one. They also stated they discussed the staffing need and determined they needed one staff person for each shift because they had one resident receiving services. On December 5, 2024, at 11:20 a.m., during phone interview, LALD-A stated she was responsible for assigning Educare courses (online training program) to all new hires, but if she could not get assign them, she would have the owner/assistant administrator (O/AA)-I assign the courses. LALD-A stated the courses should be completed prior to shadowing (observation and hands on training) but stated staff do not understand how to complete all of the courses so she set up a staff meeting for upcoming Saturday to address the issue. On December 5, 2024, at 1:22 p.m., during phone interview, O/AA-I stated upon hire, he assigned the Educare courses but not all staff are completing them, and he stated he would take responsibility for ensuring staff complete the courses going forward. On December 5, 2024, at 2:19 p.m., ULP-H stated she did not receive any dementia training and that she worked every other weekend. On December 6, 2024, at 3:38 p.m., LALD-A thought two (2) hours of dementia training was required but was not sure. The licensee's Dementia Education policy dated January 24, 2022, indicated all direct care staff would complete the required eight (8) hours of	01540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
01540	Continued From page 46 dementia care training within 160 working hours of the employment start date. Supervisors of direct-care staff would have at least eight (8) hours of initial education within 120 working hours of employment start date. The policy also stated until the initial education is completed, an employee will not provide direct care unless there is another employee on site who has completed the initial eight (8) hours of education on topics related to dementia care and who can act as a resource and assist if issues arise. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		
01560 SS=C	144G.64 (a, b, c) TRAINING IN DEMENTIA CARE REQUIRED (5) new employees may satisfy the initial training requirements by producing written proof of previously completed required training within the past 18 months. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and other dementias; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; (4) communication skills; and (5) person-centered planning and service delivery. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. This MN Requirement is not met as evidenced	01560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
01560	Continued From page 47 by: Based on interview and record review, the licensee failed to provide in written or electronic form to residents, families, or other persons who request it, a description of the dementia care training program, the categories of employees trained, the frequency of training, and the basic topics covered. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 5, 2024, at 11:20 a.m., the surveyor requested licensed assisted living director (LALD)-A to provide the licensee's notice of dementia training. LALD-A stated she would send whatever she had available, but it would also be available on the Department of Human Services (DHS) website (the notice needed to be licensee specific based on dementia care training program). Upon completion of the survey, it was not provided to the surveyor. The licensee's Notifications policy dated January 24, 2022, indicated the facility shall provide to residents, families and others who request it in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered.	01560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
01560	Continued From page 48 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01560		
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 observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a reassessment, not to exceed 14 calendar days	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
01620	Continued From page 49 from the initiation of services; conducted ongoing resident monitoring and reassessment to include all areas required on the uniform assessment tool for one of one resident (R1). Additionally, licensee failed to complete a change in condition assessment when R1 was admitted to hospice (end of life) services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: During entrance conference on December 2, 2024, at 11:23 a.m., clinical nurse supervisor (CNS)-D explained the initial RN assessment was completed upon admission then another would be completed after seven (7) days, 14 days, 30 days, then every 90 days, and with a change in condition (i.e. illness, hospitalization, fall, change in behavior or an altercation with another resident). CNS-D stated all assessments would be available in the resident electronic medical record (EMR). R1 was admitted for assisted living services on February 8, 2024, then was admitted to hospice services on March 28, 2024, and had diagnoses including early onset Alzheimer's disease, urinary incontinence, breast cancer, abnormalities of gait and mobility, and aphasia (loss of comprehension and language).	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
01620	Continued From page 50 R1's Service Plan signed February 8, 2024, indicated R1 received services including assistance with dressing and grooming, bathing, incontinence care, tube feeding, mobility, one person lift with transfers, and medication and treatment management. The service plan indicated with a check-mark, that the RN would complete an assessment/reassessment upon admission and within 14-days. There was no check mark next to "every 90 days." R1's Initial Assessment (the only RN assessment available) dated February 11, 2024, lacked the following requirements on the uniform assessment tool: -personal lifestyle preferences including: advance health care directives and end-of-life preferences, including whether a person has or wants to seek DNR order or provider orders for life sustaining treatment; -physical health status, including: -allergies and sensitivities related to medication, seasonality, environment, and food and if any are life threatening; -infectious conditions; -a review of medications according to MN (Minnesota) Statutes, section 144G.71, subd. 2, including prescriptions, OTC medications and supplements; -a review of medical, dental, and emergency room visits in the past 12 months; -a review of any reports from a PT, OT, ST, or cognitive evaluations within the last 12 months; -weight; -initial vital signs if indicated by health conditions or medications; -emotional and mental health conditions, including: -review of history of any diagnoses of mood disorders, including depression, anxiety, bipolar	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
01620	Continued From page 51 disorder, and thought or behavioral disorders; -current symptoms or mental health conditions and behavioral expressions of concern; -effective medication treatment and nonmedication interventions; -cognition, including: -a review of any neurocognitive evaluations and diagnoses, -current memory, orientation, confusion, and decision-making status and ability; -communication and sensory capabilities, including: hearing; -pain, including: -location, frequency, intensity, and duration; and -effectiveness of medication and nonmedication alternatives; -skin conditions; -nutritional and hydration status and preferences; -list of treatments, including type, frequency, and level of assistance needed; -nursing needs, including potential to receive nursing-delegated services; -risk factors, including: -risk for falling including history of falls; -emergency evacuation ability; -complex medication regimen; -risk for dehydration; -risk for emotional or psychological distress due to personal losses; -unsuccessful prior placements; -elopement risk; -smoking; -alcohol and drug use; -who has decision-making authority for the resident, including: -the presence of any advance health care directive or other legal document that establishes a substitute decision maker;	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
01620	Continued From page 52 -the scope of decision-making authority; and -the need for follow-up referrals for additional medical or cognitive care by health professionals. R1's medical record lacked a 14-day assessment, change in condition assessment related to the hospice admission, and quarterly assessments. On December 3, 2024, at 12:31 p.m., after reviewing R1's initial RN assessment, the surveyor asked CNS-D if there were any additional assessments available to view and CNS-D stated, "I cannot find them, I did them on paper," and continued searching. On December 3, 2024, at 4:00 p.m., the surveyor had asked if the additional assessments were located and available and CNS-D stated she did not have them but would enter the paper assessments into R1's EMR. On December 4, 2024, at 3:30 p.m., the surveyor asked CNS-D if she located R1's RN assessments or if they were available on the electronic health record, and she said she was waiting for administrative access to R1's EMR to "dig further to locate the assessments." The surveyor explained the previous assessments completed by the previous licensee's RN (before the change of ownership) were visible along with CNS-D's assessment dated February 11, 2024. CNS-D was unable to provide further explanation why the assessments were not available. On December 6, 2024, at 11:02 a.m., CNS-D stated she was unaware of the required content of the uniform assessment tool, she went by what the computer provided. She explained there were options to select the question to answer and if the	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
01620	Continued From page 53 questions were unanswered, they remained on the assessment. She stated she did not receive training and thought what was asked on the assessment was sufficient. CNS-D stated post hospitalizations, illnesses, injuries, decline and being admitted to hospice would warrant a change in condition assessment but was told it was not necessary, so she did not complete one. The Minnesota Administrative Rule 4659.0150 dated August 11, 2021, indicated each facility must develop a uniform assessment tool to include all the required elements. The licensee's Assessment and Reassessment policy dated January 24, 2022, indicated the RN would complete comprehensive assessments to include all required content of the uniform assessment tool. The licensee's Comprehensive Nursing Assessment policy dated January 24, 2022, indicated the RN would conduct a comprehensive assessment utilizing a uniform assessment tool that included all the required content according to MN Rule 4659.0150. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
01640	Continued From page 54 include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure residents' revised service plan were authenticated by the resident or resident's representative for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: R1 was admitted for assisted living services on February 8, 2024, then was admitted to hospice	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
01640	Continued From page 55 services on March 28, 2024, and had diagnoses including early onset Alzheimer's disease, urinary incontinence, breast cancer, abnormalities of gait and mobility, and aphasia (loss of comprehension and language). R1's Service Plan signed upon admission on February 8, 2024, indicated R1 received services including dressing and grooming, bathing, incontinence care, tube feeding, mobility, one person lift with transfers, and medication and treatment administration. R1's Service Plan, unsigned, printed on December 4, 2024, indicated the following services had been changed: -apply splints (hand and wrist brace) twice a day was added; -ensure alternating pressure mattress (air mattress to help prevent pressure sores) is alternating four times a day was added; -one person lift was changed to full assist using full body lift (Hoyer) using two staff three times per day; -monthly weight check changed to every two weeks; -monthly vital signs check (blood pressure, temperature, pulse, oxygen saturation, respirations) changed to daily; -passive range of motion (staff assisted) added to service plan three times per day; -cyst care (type of wound care for blister which was resolved) was added but currently not needed; -oxygen therapy as needed when oxygen saturation is below 90% was added, but oxygen is not available on site; -repositioning every two hours and as needed was added; -gastrostomy tube care (opening in the stomach)	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
01640	Continued From page 56 was added three time a day; -skin integrity check four times per day was added; -oral care assistance with suction machine three times per day was added; -order and return library books once a month was added; -bowel movement monitoring four times a day was added; and -daily wound care by unlicensed personnel and wound care by a licensed nurse three times per week was performed but not added to the service plan. R1's service plan changes lacked authentication or signature from R1 or R1's designated representative. On December 2, 2024, through December 4, 2024, throughout the survey, the surveyor had observed a tumor wound care completed by a registered nurse, medication, water and formula administration through the gastrostomy tube, repositioning while in bed, and laundry for R1. On December 2, 2024, at 11:23 a.m., during entrance conference, clinical nurse supervisor (CNS)-D explained she was responsible for updating the service plan and would discuss the changes with the resident or the resident's representative but she did not necessarily have the representative sign it. CNS-D stated they signed it during the six-month county meetings. The licensee's Service Plan policy revised January 24, 2022, indicated the service plan must be revised, if needed, based on resident review or reassessment and the initial service plan and any revisions are signed by a representative from licensee and the resident or resident's	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
01640	Continued From page 57 representative, indicating agreement with the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01690 SS=F	144G.71 Subdivision 1 Medication management services (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure	01690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
01690	Continued From page 58 security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to follow their own policy related to the security and accountability of controlled substances being within a secured safe within a separately locked compartment. This directly affected one of one resident (R1) with controlled substances, but had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On December 2, 2024, at 10:45 a.m., during facility tour with licensed assisted living director (LALD)-A and unlicensed personnel/house manager (ULP)-B, the surveyor observed a rambler style home with one level and a basement. The main level to the right consisted of three bedrooms which three were unoccupied. The unoccupied bedroom next to R1's room was the medication room per LALD-A and ULP-B. The unlocked room consisted of a full/queen sized bed, dorm sized black refrigerator, unlocked medication cart, and white cabinets containing miscellaneous supplies. The surveyor noticed the	01690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
01690	Continued From page 59 medication cart had an oval metal button with a keyhole which was popped out indicating it was unlocked and noted a set of keys sitting directly on top of the medication cart. The surveyor inquired about the unlocked medication cart and ULP-B explained it was always unlocked but there was a locked drawer that held R1's narcotic medication (hydrocodone/acetaminophen). The surveyor asked if the keys on top of the medication cart was for the locked drawer, ULP-B stated yes. ULP-B stated the bedroom door was always left open because they always left the front door of the home locked and no one would have access to the medication cart. The surveyor asked about visitors or staff, LALD-A and ULP-B both explained they never let visitors out of their sight and would not allow them to walk around the home alone. On December 2, 2024, at 3:15 p.m., clinical nurse supervisor (CNS)-D stated she tried implementing a system to count R1's narcotic by using a narcotic logbook but R1's hospice (end of life service) nurse counted R1's narcotic with licensee's ULPs twice a week when visiting R1. CNS-D stated she was told by the hospice nurse they were going to be in control of the narcotics, so she stopped trying to implement the narcotic count among the facility staff. R1 had diagnoses including early onset Alzheimer's disease, urinary incontinence, abnormalities of gait and mobility, and aphasia (loss of comprehension and language). R1's Service Plan dated February 8, 2024, indicating R1 received services including dressing and grooming, bathing, incontinence care, tube feeding, mobility, transfers with full body mechanical lift, and medication and treatment	01690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
01690	Continued From page 60 administration. R1's Initial Assessment dated February 11, 2024, indicated R1 required medications to be stored in the medication cart. The assessment lacked instructions on how to store controlled substances. R1's Medication Administration Record (MAR) dated November 1, 2024, through November 30, 2024, indicated R1 required the following medication: -hydrocodone/acetaminophen (Norco) 5-325 milligrams (mg) (for pain): Take one tablet by gastronomy tube three times a day and one-half tablet every 8 hours as needed (PRN) for pain. R1's provider orders dated March 28, 2024, ordered Norco 5-325 mg (schedule II-controlled substance) -one tablet scheduled every eight (8) hours and one tablet every four (4) hours PRN for severe pain. (The MAR indicated one-half tablet every 8 hours PRN.) The licensee's Storage/Control of Medications policy dated January 24, 2022, indicated when controlled substances were being managed, stored, and secured by [Licensee], the registered nurse (RN) will provide for security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations. The policy also indicated schedule II controlled substances were stored in a separately locked compartment. The RN was responsible for establishing the protocol related to monitoring/securing controlled medications based on the initial assessment and risk for diversion. No further information provided.	01690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
01690	Continued From page 61 TIME PERIOD FOR CORRECTION: Seven (7) days	01690		
01750 SS=F	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse had instructed the unlicensed personnel (ULP) in the proper methods to administer medications and verified the ULP had demonstrated the ability to competently follow the procedures when medication administration was delegated to three of three employees (unlicensed personnel (ULP)-C, unlicensed personnel/house manager (ULP)-B, and ULP-H). The licensee also failed to ensure the registered nurse (RN) documented resident-specific instructions for one of one resident (R1) whose medication administration was delegated to unlicensed personnel (ULP). This practice resulted in a level two violation (a	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
01750	Continued From page 62 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: ULP-C ULP-C was hired on September 25, 2024, to provide direct care services to the licensee's residents. On December 2, 2024, at 4:40 p.m., ULP-C stated she was trained on medication administration by the nurse but did not specify details of the training. ULP-B ULP-B was hired on an unknown date, prior to the change of ownership, and began training on February 7, 2024, with the current licensee. ULP-B was hired to provide direct care and services to the licensee's residents and assist with managerial duties. During observation and interview on December 3, 2024, at 9:44 a.m., the surveyor and ULP-B observed a box of R1's EpiPen (epinephrine 0.3 milligram auto-injector). ULP-B stated she never received training on how to administer the EpiPen. On December 3, 2024, at 1:55 p.m., ULP-B unlocked the medication cart, prepared R1's medications, locked the medication cart and administered medications through R1's gastrostomy tube (opening in the stomach).	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
01750	Continued From page 63 ULP-H ULP-H was hired on October 15, 2024, to provide direct care services to the licensee's residents. On December 5, 2024, at 2:19 p.m., ULP-H stated she never received training on how to administer the EpiPen, nor did she know what it was for. R1's medication administration record (MAR) dated November 1, 2024, through November 30, 2024, indicated the following: -ULP-B administered medications to R1 at various times (6:00 a.m., 9:00 a.m., 10:00 a.m., and 2:00 p.m.) 19 out of 30 days; and -ULP-C administered medications to R1 at various times (6:00 a.m., 8:00 a.m., 9:00 a.m., 10:00 a.m., 2:00 p.m., and 10:00 p.m.) 11 out of 30 days; and -ULP-H administered medications to R1 at various times (6:00 a.m., 8:00 a.m., 9:00 a.m., 2:00 p.m., and 10:00 p.m.) 13 out of 30 days. ULP-C's employee record lacked evidence the RN instructed them in the proper methods to administer the medications and demonstrated the ability to competently follow the procedures. ULP-C's record contained no evidence of medication training or competency evaluations. ULP-B's employee record contained no evidence of medication training or competency evaluation on EpiPen injections. On December 4, 2024, at 12:00 p.m., R1's physician assistant (PA)-F who made an in-house visit with R1 stated the EpiPen was last filled in 2022, and felt it should remain a current order due to R1's peanut allergy.	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
01750	Continued From page 64 On December 6, 2024, at 11:02 a.m., CNS-D stated she did not train staff on how and when to administer the EpiPen, "because it literally never been used, and the things she is allergic to is kept away." She stated the information on the MAR was entered by someone else (the pharmacy uses the language provided on the physician orders) but stated she would have been more descriptive if she had entered the information. The licensee's Staff Competency policy dated January 24, 2022, indicated all residents would receive quality services delivered by staff who were educated and competent in the delivery of assisted living services. The policy indicated the clinical nurse supervisor was responsible for assessing competency throughout the orientation process and that no one would provide direct care to residents on behalf of the licensee before successfully passing the competency evaluation. In addition, staff members would not perform delegated tasks for when they had not demonstrated competence. The policy indicated the licensee would maintain the following documentation related to competency evaluations: - facility name, location, and license number; - name of topic and methodology of training (verbal, observation, written or practicum); - date and total time spent; - name/ title of instructor and evaluator with signatures and a statement attesting that the employee successfully passed the training and competency evaluation; and - name/ title of the staff person completing the competency evaluation and at statement attesting that the person successfully completed the training as described.	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
01750	Continued From page 65 No further information was provided. TIME PERIOD FOR CORRECTION: seven (7) days	01750		
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure accurate documentation of medication administration; failed to ensure prescribed medications were available for use; and failed to ensure medications were transcribed as prescribed for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
01760	Continued From page 66 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: R1 was admitted for assisted living services on February 8, 2024, then was admitted to hospice services (end of life care) on March 28, 2024, and had diagnoses including early onset Alzheimer's disease, urinary incontinence, breast cancer, abnormalities of gait and mobility, and aphasia (loss of comprehension and language). R1's Service Plan signed February 8, 2024, indicated R1 received services including dressing and grooming, bathing, incontinence care, tube feeding, mobility, one person lift with transfers, and medication and treatment administration. DOCUMENTATION OF MEDICATION ADMINISTRATION On December 2, 2024, at 2:20 p.m., clinical nurse supervisor (CNS)-D completed a wound dressing change and applied crushed antibiotic to R1's tumor wound to the upper left chest area. R1's hospice plan of care (orders) dated November 21, 2024, indicated the following orders: -apply crushed Flagyl 500 milligrams (mg) (antibiotic) to wound bed with each wound change of dressing two times a week and daily as needed R1's medication administration record (MAR) dated November 1, 2024, through November 30, 2024, indicated the following: -Flagyl 500 mg tablet-finely crush tablet and apply to open wound bed after cleansing three times a	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
01760	Continued From page 67 week. Wound care to be done daily by "facility staff" and weekly by hospice RN with wound assessment. The medication was scheduled every week on Mondays, Wednesdays, and Fridays and each of those day were documented of completion by unlicensed personnel/house manager (ULP)-B and unlicensed personnel (ULP)-C. R1's record lacked clear instructions on who was responsible for completing wound care three times per week with antibiotic administration. During interview on December 5, 2024, at 12:39 p.m., ULP-B stated she did not realize she was charting on the Flagyl administration, which she was not doing. She stated she knew it was getting completed by the hospice nurse and by CNS-D. During interview on December 6, 2024, at 11:02 p.m., CNS-D stated the Flagyl administration on the MAR was being documented incorrectly. She stated she usually charted under observation notes and should have been documenting on the MAR, but due to not having a valid RN licensure, she couldn't change her title on the electronic health record so she didn't feel comfortable charting on the MAR. CNS-D also explained the hospice nurse did not have rights to chart on R1's MAR. She explained they cannot go back to fix the issue, but going forward they will make changes. TRANSCRIPTION ERROR R1's hospice plan of care (orders) dated November 21, 2024, indicated the following orders: -hydrocodone 5 mg- Acetaminophen 325 mg (Norco) tablet-one tablet per gastronomy tube (g-tube) every eight (8) hours scheduled and 1	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
01760	Continued From page 68 tablet every four (4) hours as needed (PRN) for pain; and -lorazepam 0.5 mg tablet-one tablet by mouth every four (4) hours for anxiety/agitation (should be PRN). R1's Medication Administration Record (MAR) dated November 1, 2024, through November 30, 2024, indicated the following: -acetaminophen 650 mg suppository-insert one suppository rectally every four (4) hours as needed for pain or fever; -prochlorperazine 25 mg suppository-insert one suppository rectally twice daily as needed for nausea and vomiting; -hydrocodone/acetaminophen 5-325 mg tablet-one tablet per g-tube every eight (8) hours and ½ tab tablet every 8 hours PRN (orders indicate 1 tablet PRN every 4 hours); -ibuprofen 100 mg/5 ml-give 15 ml every six (6) hours for pain/agitation/restlessness (not a current order); and -lorazepam 2 mg/1 milliliter (ml) oral concentrate-give 0.25 ml (0.5 mg) by mouth every four (4) hours PRN (current orders are for tablet form). R1's Task Administration Record (TAR) dated November 1, 2024, through November 30, 2024, indicated the following: "MED ADM Remove old SCOPOLAMINE patch before placing new one;" and "MED ADM Please check placement of scopolamine patch before placing new one" (There were no current orders for the patch). During interview on December 3, 2024, at 12:53 a.m., the surveyor reviewed R1's MAR and asked to see orders for ibuprofen, acetaminophen suppositories, and lorazepam concentrate.	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
01760	Continued From page 69 CNS-D stated acetaminophen suppositories was discontinued because R1 was taking Norco which had acetaminophen and ibuprofen should have been stopped. The scopolamine patch should not have been on the TAR because R1 was taking a oral medication in place of the patch. CNS-D stated she entered the orders in the MAR and thought it was updated, but "apparently it didn't stick." These changes would have been made when R1 was admitted to hospice. During interview on December 4, 2024, at 12:00 p.m., R1's physician assistant (PA)-F who made an in-house visit with R1, stated she coordinated with hospice regarding R1's medications and care. PA-F stated prochlorperazine suppositories and ibuprofen were not a current order. She also indicated the lorazepam was changed from concentrate to tablets. MEDICATION AVAILABILITY R1's hospice provider orders signed on November 21, 2024, indicated hospice originally ordered 0.5 mg lorazepam tablets on March 28, 2024. The licensee did not ensure lorazepam was available at the facility. During interview on December 4, 2024, at 12:49 p.m., hospice nurse (RN)-G stated there were no stock of lorazepam tablets but would order them. She also indicated she did the full wound care (with antibiotic) every Wednesday and Friday while CNS-D did every Monday. RN-G confirmed the hydrocodone/acetaminophen order was 1 tablet every 8 hours scheduled and one tablet every 8 hours as needed. The licensee's Medication Orders policy dated January 24, 2022, indicated the licensee would maintain a current written or electronically	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
01760	Continued From page 70 recorded prescription for all prescribed medications managed for the resident. The licensee's Service Plan for Medication Management policy dated January 24, 2022, indicated the medication management plan would be kept current and updated with any changes. The policy also indicated the licensed nurse was responsible for assessing medications to assure that all medications were current and ordered by the prescriber and to identify any expired or outdated medications, which would be disposed according to policy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prescription medications were securely locked in a substantially constructed compartment and permitted only authorized personnel to have access. 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	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
01880	Continued From page 71 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: During facility tour on December 2, 2024, at 10:45 a.m., the surveyor observed three empty bedrooms and one occupied bedroom on the first level (all on the same side of the house) and an empty bedroom on the lower level. The bedroom right next to R1's room was the licensee's "medication room." The door to the medication room was open and upon entry, the surveyor observed a made bed, black mini refrigerator, portable medication cart, and white cabinets to store various supplies. The medication cart was in straight view from the entry door and the metal lock button was popped open indicating it was unlocked. The surveyor also observed keys sitting on top of the medication cart. The surveyor inquired why the medication cart was unlocked, and both unlicensed personnel/house manager (ULP)-B and licensed assisted living director (LALD)-A stated the medication cart was never locked but the narcotic box was (drawer within the cart). ULP-B showed the surveyor R1's non-controlled medications in multiple drawers and showed how the narcotic drawer was locked (medications present). LALD-A asked the surveyor if the medication cart was supposed to be locked and the surveyor asked the LALD-A, "how do you ensure medications are not accessible to unauthorized people?" LALD-A explained they did not let visitors walk around but they could not ensure it would not be tampered with. LALD-A also explained they did not let staff	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
01880	Continued From page 72 keep the keys on their person because staff could "misplace the keys," so they asked staff to keep the keys in the unlocked white cabinet next to the medication cart. They confirmed the keys on top of the cart was for the medication cart. The surveyor asked ULP-B to lock the medication cart and when ULP-B attempted to push the metal button in, it did not lock (drawers were still able to pull out). The surveyor showed ULP-B the two metal flaps on each end of the drawers needed to be turned inward after pushing the metal button in. The metal flaps kept the drawers from pulling out. The surveyor asked LALD-A if there were medications in the black refrigerator, she said no. On December 2, 2024, at 3:15 p.m., clinical nurse supervisor (CNS)-D explained she didn't expect the medication cart to be locked because they were serving just one resident and didn't feel there was a risk for unauthorized access to the medications. During observation and interview on December 3, 2024, at 1:00 p.m., the surveyor inquired about R1's order for lorazepam and CNS-D stated there should be so both surveyor and CNS-D entered the already opened medication room then opened the medication refrigerator and found the following items: -R1's acetaminophen suppositories 650 milligrams (mg) (for pain/fever when unable to swallow medications); -R1's lorazepam concentrate 2 mg/ml (milliliters) (for anxiety); -R1's prochlorperazine suppositories 25 mg (for nausea/vomiting); -R1's bisacodyl suppositories 10 mg (for constipation); and -R2's (discharged resident) tobramycin sulfate 40 mg/1 ml vial (used for people with certain	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
01880	Continued From page 73 inherited lung condition that have ongoing lung bacterial infections). During interview and medication cart review on December 3, 2024, between 9:45 a.m. and 10:00 a.m., some of the following medications were observed in the medication cart: baclofen (treat muscle spasms), epinephrine pen (for severe allergic reaction), metoclopramide for nausea) senna (constipation), MiraLAX (stool softener), hyoscyamine (reduce excess secretions), metronidazole (antibiotic), milk of magnesia (constipation), guaifenesin (congestion), Benadryl (seasonal allergies), nystatin powder (anti-fungal), cephalexin (antibiotic), ibuprofen (fever/pain), albuterol sulfate (shortness of breath), and hydrocodone/acetaminophen (narcotic for pain). ULP-B explained she never closed the door to the medication room and did not know how to lock the medication cart until the surveyor showed her. She explained staff stayed nearby when R1 had visitors, so they did not feel there was any risk of unauthorized access to medications. On December 3, 2024, at 1:55 p.m., ULP-B unlocked the medication cart, prepared R1's medications, locked the medication cart and administered medications through R1's gastrostomy tube (opening in the stomach). The licensee's Storage/Control of Medications policy dated January 24, 2022, indicated the licensee would provide storage for medications outside of the resident's private living space, all prescription drugs are securely locked in substantially constructed compartments according to the manufacturer's directions. Only authorized personnel have access to the stored medications. The policy also indicated when controlled substances are being managed,	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
01880	Continued From page 74 stored, and secured by licensee, the registered nurse would provide for security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to dispose of expired medications for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
01890	Continued From page 75 R1 was admitted to the licensee on February 8, 2024, and hospice (end of life service focusing on comfort) on March 28, 2024. R1 had diagnoses including early onset Alzheimer's disease, urinary incontinence, breast cancer, abnormalities of gait and mobility, and aphasia (loss of comprehension and language). R1's Service Plan signed February 8, 2024, indicating R1 received services including dressing and grooming, bathing, incontinence care, tube feeding, mobility, transfers with full body mechanical lift, and medication and treatment administration. On December 3, 2024, at 9:44 a.m., during medication cart review, the surveyor found the following medications for R1: -epinephrine 0.3 milligram (mg)-two injectable doses in one box for severe allergic reaction affecting the airway (expired May 2024); -cephalexin 250 mg/5 milliliters (ml), amount in bottle unknown (ordered by provider on May 13, 2024, for seven (7) days only and should have been removed from the medication cart once administered for 7 days); and -ibuprofen liquid 100 mg/ 5 ml, amount in bottle unknown (no current order). After medication cart review, unlicensed personnel/house manager (ULP)-B stated there were no medications in the small black refrigerator. The surveyor inquired about R1's lorazepam order (helps with anxiety) on the medication administration record (MAR), ULP-B was unaware if lorazepam was even available. During observation and interview on December 3, 2024, at 1:00 p.m., the surveyor inquired about R1's order for lorazepam and clinical nurse supervisor (CNS)-D stated there should be so	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
01890	Continued From page 76 both surveyor and CNS-D opened the medication refrigerator and found the following items: -R1's acetaminophen suppositories 650 mg, (for pain/fever when unable to swallow medications) (no current order); -R1's lorazepam concentrate 2 mg/ml, quantity 30 ml (expired on July 31, 2024) (no current order); -R1's prochlorperazine suppositories 25 mg, quantity 7 suppositories (for nausea/vomiting) (no current order). The surveyor asked who was responsible for checking for expired medications, CNS-D said, "ultimately it's me." On December 4, 2024, at 3:27 p.m., CNS-D stated she assumed ULP-B oversaw checking for expired medications. CNS-D stated she would check new medications against the medication administration record and observe for signs of side effects. She also stated ibuprofen was no longer a current order and R1 should not be administered that medication. The licensee's Disposition and Disposal of Medications policy dated January 24, 2022, indicated any medication under [Licensee's] storage after the termination of the medication management program for a resident, that are discontinued or expired or upon a resident's death will be disposed of by a licensed nurse. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01910	Continued From page 77 the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to dispose of discharged medication for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01910	Continued From page 78 During facility tour on December 2, 2024, at 10:45 a.m., the surveyor observed an unoccupied bedroom with a bed, dorm sized small black refrigerator, medication cart, and storage cabinets for miscellaneous items. During the entrance conference on December 2, 2024, at 11:23 a.m., clinical nurse supervisor (CNS)-D stated the licensee provided medication management services for the licensee's one resident. Licensed assisted living director (LALD)-A explained prior to the change in ownership on February 8, 2024, the previous licensee/owner had three residents including R1 and two residents on ventilators (R2 and R3). LALD-A explained the current licensee could not care for residents on ventilators, so R2 and R3 discharged from the facility prior to the change in ownership. On December 3, 2024, at 9:44 a.m., unlicensed personnel/house manager (ULP)-B stated there were no medications in the small black refrigerator. At that time, the medication refrigerator was not reviewed. During observation and interview on December 3, 2024, at 1:00 p.m., the surveyor inquired about R1's order for lorazepam and CNS-D stated there should be lorazepam available, so both surveyor and CNS-D opened the medication refrigerator and found the following item for R2: - tobramycin sulfate 40 mg/1 ml vial, quantity approximately 30 vials in a clear plastic bag (used for people with certain inherited lung condition that have ongoing lung bacterial infections) CNS-D was unaware R2's medication was in the medication refrigerator and that it should have been disposed of when R2 discharged from the facility. When asked who was responsible for	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01910	Continued From page 79 checking expired medications, CNS-D said, "ultimately it's me." R2's record lacked documentation of medication disposal for tobramycin sulfate to include the medication name, strength, prescription number as applicable, quantity, to whom the medication was given, date of disposition, and names of the staff persons involved in the disposition. The licensee's Disposition and Disposal of Medications policy dated January 24, 2022, indicated any medication under [Licensee's] storage after the termination of the medication management program for a resident, that are discontinued or expired or upon a resident's death will be disposed of by a licensed nurse. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
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	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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 80 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 treatment or therapy management plan to include all required content for one of one resident (R1) who received multiple treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: R1's individualized treatment plan did not indicate what treatments would be delegated to	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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 81 unlicensed personnel, it was not updated to the current needs of the resident, did not provide clear documentation of specific resident instructions relating to the treatment administration, and provide a statement of the type of services that would be provided by the licensee. R1's Service Plan signed February 8, 2024, indicated a check mark next to "See Treatment Protocols/Flowsheet," but the treatment plan was blank and did not specify what treatments would be provided. During the entrance conference on December 2, 2024, at 11:23 a.m., clinical nurse supervisor (CNS)-D stated the licensee provided treatment management services, including orthotic braces (hand splints), wound care, and tube feeding (formula given through opening of stomach). R1 had diagnoses including early onset Alzheimer's disease, urinary incontinence, breast cancer, abnormalities of gait and mobility, and aphasia (loss of comprehension and language). WOUND CARE On December 2, 2024, at 2:20 p.m., CNS-D completed a wound dressing change and applied crushed antibiotic to R1's tumor wound to the upper left chest area. CNS-D noted regular gauze was placed between the Vaseline gauze (keeps from sticking to the wound) and the wound which caused the regular gauze to get embedded into the wound and bled upon removal. CNS-D stated, "I will have to do more staff education." R1's prescriber orders signed November 21, 2024, instructed the following, "Wound care to breast tumor: cleanse with wound cleanser, apply	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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 82 crushed Flagyl (antibiotic medication) to wound bed, apply vasaline [sic] gauze, apply calcium alginate (promotes wound healing and absorbs drainage), cover with ABD (extra thick dressing to manage draining wounds) and paper tape 2x week. Change daily as needed for drainage. R1's Medication Administration Record (MAR) dated November 1, 2024, through November 30, 2024, indicated unlicensed personnel/house manager (ULP)-B and unlicensed personnel (ULP)-C documented their initials for completing the wound care as ordered by the provider three (3) times per week on November 1, 4, 6, 8, 11, 13, 15, 18, 20, 22, 24, 26, and 29, 2024. The MAR also indicated wound care to be done daily by facility staff and weekly by hospice RN [registered nurse] with wound assessment. May change dressing as needed for increased drainage or if bandage is dislodged. The MAR indicated three (3) times a week, where the provider orders indicated two (2) times per week. R1's Task Administration Record (TAR) dated November 1, 2024, through November 30, 2024, indicated ULPs documented daily at 10:00 a.m., under "CYST CARE-Apply dry dressing to left chest cyst site to protect wound from rubbing on clothing. Change daily and PRN [as needed]." On December 5, 2024, at 11:02 a.m., CNS-D stated the "cyst care" was an old order and should have been only performing and documenting on the ABD dressing change to the chest tumor wound, not on the full wound care done by a licensed nurse. CNS-D stated the instructions on the TAR and MAR were not clear and lacked procedures when to notify a registered nurse (RN) when a problem arose.	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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 83 TUBE FEEDING R1's prescriber orders dated November 21, 2024, instructed licensee to administer 240 cubic centimeters (cc) (1 milliliter/ml = 1 cc) of Nestle Fibersource HN (high nutrition) formula through g-tube four (4) times per day. R1's MAR dated November 1, 2024, through November 30, 2024, instructed staff to administer 240 cc of Nestle 1.2 three (3) times per day at 6:00 a.m., 2:00 p.m., and 6:00 p.m. Orders indicated 4 times per day. R1's TAR dated November 1, 2024, through November 30, 2024, instructed staff to administer Isosource 1.5 formula through g-tube four times per day at 6:00 a.m., 10:00 a.m., 2:00 p.m., 6:00 p.m. On December 3, 2024, at 10:00 a.m., the surveyor observed numerous containers of formula in R1's bedroom closet and each container of Nestle Fibersource HN formula had 250 ml of formula. On December 3, 2024, at 1:55 p.m., the surveyor observed ULP-B administer medications, water, and one container of formula through R1's gastrostomy tube (g-tube). ULP-B explained that the hospice provider decreased the frequency of formula administration from four to three times per day due to weight gain. R1's unsigned service plan printed on December 4, 2024, indicated R1 received g-tube feedings four (4) times per day by "staff." R1's formula feeding frequency was not updated to reflect hospice's verbal orders and amount of formula was not transcribed correctly.	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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 84 SPLINTS On December 4, 2024, at 10:24 a.m., ULP-B showed the surveyor two hand splints that were used for two hours per day. ULP-B explained she provided training to new staff but they had a difficult time getting them on R1's fingers due to contractures. ULP-B stated she was the only one that applied them. R1's Service Plan signed February 8, 2024, indicated a check mark next to "See Treatment Protocols/Flowsheet," but the treatment flowsheet was blank and service plan did not specify what treatments would be provided. R1's Initial Assessment dated February 11, 2024, lacked an assessment on the use of splints for R1's hand contractures (loss of joint motion). R1's Task Administration Record (TAR) dated November 1, 2024, through November 30, 2024, indicated staff applied the hand splints to both hands twice a day for two hours at 10:00 a.m., and 4:00 p.m., by initialing their name. On December 4, 2024, at 1:18 p.m., CNS-D stated R1's splints were being discontinued due to discomfort and did not know they were still being applied. OXYGEN R1's TAR dated November 1, 2024, through November 30, 2024, indicated ULP's documented daily at 8:00 a.m., 4:00 p.m., and 8:00 p.m., for the following, "Oxygen 2-4L [liters per minute] PRN per NC [nasal canula] for sats [oxygen saturation] below 90%, check sats every shift and PRN."	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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 85 R1's unsigned service plan printed on December 4, 2024, indicated R1 required assistance by "staff" with oxygen therapy three (3) times every day and as needed (PRN), cyst care once every day (old wound care), and tube feeding four (4) times per day. On December 3, 2024, at 1:00 p.m., CNS-D stated R1 did not have oxygen available at the facility nor had she in the past, but would contact R1's hospice agency to have them deliver it right away if needed. R1's individualized treatment plan did not indicate what treatments would be delegated to unlicensed personnel, it was not updated to the current needs of the resident, and did not provide clear documentation of specific resident instructions relating to the treatment administration. On December 4, 2024, at 12:00 p.m., physician assistant (PA)-F with an outside provider was at the facility and explained she did not order oxygen therapy, but hospice may have. PA-F also explained wound care is to be completed three times a week and daily dressing change with ABD dressing only. On December 4, 2024, at 12:49 p.m., hospice registered nurse (RN)-G was at facility to observe R1 and stated the current orders for wound care was twice a week. The licensee's Treatment and Therapy Management policy dated January 24, 2022, indicated the licensee would develop and maintain a current individualized treatment and therapy management plan for each resident receiving ordered or prescribed treatments or	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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 86 therapy services, which addresses the following: -type of services to be provided; -procedures for documenting treatments or therapies; -procedures for monitoring treatments or therapies to prevent possible complications or adverse reactions; -identification of treatment or therapy tasks that will be delegated to ULPs; -procedures for notifying a RN or appropriate licensed health professional when a problem arises related to the treatment or therapy service; and -monitoring of treatment or therapy to prevent possible complications or adverse reactions. In addition, the policy indicated treatment or therapy management record must be current and updated when there are any changes. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01950 SS=F	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
01950	Continued From page 87 professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prior to delegating nursing tasks of prescribed treatment administration, the registered nurse (RN) trained in the proper methods to perform the task or procedure for each resident and verified the ULPs were able to demonstrate the ability to competently follow the procedure for one of one employee (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 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: ULP-C was hired on September 25, 2024, to provide services to licensee's residents. ULP-C's training record lacked training and competency on splint administration. During interview on December 2, 2024, at 4:440 p.m., ULP-C stated she received training on wound care and medication administration by clinical nurse supervisor (CNS)-D and received Hoyer (full body mechanical lift) and personal care training by ULP-B.	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
01950	Continued From page 88 During interview and observation on December 4, 2024, at 10:24 a.m., unlicensed personnel/house manager (ULP)-B showed the surveyor R1's splints (padded with Velcro straps made of terrycloth material). She explained they were applied to R1's hands every morning for two hours and that she provided splint training to all new hires. During interview on December 4, 2024, at 1:18 p.m., CNS-D stated R1's splints were being discontinued due to discomfort and did not realize they were still being applied to R1. She did not perform training or competency checks on R1's splints. R1's record lacked evidence of physician orders for the hand splints. R1's Task Administration Record (TAR) dated November 1, 2024, through November 30, 2024, indicated staff (ULP-B, ULP-C, ULP-E, and ULP-H) applied the hand splints to both hands twice a day for two hours at 10:00 a.m., and 4:00 p.m., by initialing their name. Instructions for use of splints obtained from restorativemedical.com (RM Restorative Medical 20715 RM BendEase Hand) indicated to read all instructions before use and use as directed by the clinician. Under "Warnings:" it indicated to consult a clinical professional before using this splint. Per Minnesota Statutes 2024 under 144G.08 Definitions. Subdivision 71. Treatment or Therapy: "Treatment" or "therapy" means the provision of care, other than medications, ordered or prescribed by a licensed health professional and provided to a resident to cure, rehabilitate, or ease symptoms. The licensee's Delegation of Assisted Living Tasks policy dated January 24, 2022, indicated when the registered nurse (RN) or licensed health professional is responsible for appropriately delegating tasks to staff who are competent and	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
01950	Continued From page 89 possess the knowledge and skills consistent with the complexity of the tasks. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure it had a physician order for one of one resident (R1) receiving treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on December 2, 2024, at 11:23 a.m., clinical nurse supervisor	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
01970	Continued From page 90 (CNS)-D stated the licensee provided treatment and/or therapy services for the licensee's one resident. R1 had diagnoses including early onset Alzheimer's disease, urinary incontinence, abnormalities of gait and mobility, and aphasia (loss of comprehension and language). R1's Service Plan dated February 8, 2024, indicated a check mark next to "See Treatment Protocols/Flowsheet," but the treatment plan was blank and did not specify what treatments would be provided. R1's Initial Assessment dated February 11, 2024, lacked an assessment on the use of splints for R1's hand contractures (loss of joint motion). R1's Task Administration Record (TAR) dated November 1, 2024, through November 30, 2024, indicated staff applied the hand orthosis/splints to both hands twice a day for two hours at 10:00 a.m., and 4:00 p.m., by initialing their name. During observation on December 2, 2024, at 2:20 p.m., the surveyor observed R1 lying in bed with arms bent inward at the elbows, both wrists turned in, and hands forming a "fist." During observation and interview on December 4, 2024, at 10:24 a.m., unlicensed personnel/house manager (ULP)-B showed the surveyor the hand splints R1 used for both hands (soft, breathable splint with several Velcro straps to keep splint in place while on fingers, hand, and wrist). ULP-B explained they were applied for two hours a day and that she provided training to new hires on how to properly apply them, but a lot of staff had difficulty getting them on due to R1's fingers.	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
01970	Continued From page 91 ULP-B stated she applied them every day because she was comfortable applying them and that R1 had been wearing them for three years. R1's record lacked evidence of physician orders for the hand splints. On December 5, 2024, at 11:02 a.m., CNS-D stated she did not know if there was an order for R1's splints and thought regulation required the order to be renewed at a minimum every 90 days when asked how often orders should be renewed. CNS-D stated if the licensee were to continue using the splints, they would obtain a prescriber's order but since staff had been doing a good job providing range of motion, she felt the splints were ineffective. She also indicated she had not seen discontinuation orders on R1's online provider portal (where orders are posted). R1's instructions for use of splints (RM Restorative Medical 20715 RM BendEase Hand) indicated to read all of the instructions before use and use as directed by the clinician. Under "Warnings:" it indicated to consult a clinical professional before using this splint. Per Minnesota Statutes 2024 under 144G.08 Definitions. Subdivision 71. Treatment or Therapy: "Treatment" or "therapy" means the provision of care, other than medications, ordered or prescribed by a licensed health professional and provided to a resident to cure, rehabilitate, or ease symptoms. The licensee's Prescriber's Orders policy date January 24, 2022, indicated a current, written prescriber's order must be obtained for any treatment or medication administration provided to a resident.	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
01970	Continued From page 92 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for one of one resident (R1) who a utilized a hospital-style bed rail. This resulted in issuance of an immediate correction order on December 3, 2024. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 2, 2024, at 10:45 a.m., during facility tour, the surveyor observed R1 lying in a	02310	During the course of the survey, the licensee took action to mitigate the immediate risk. Noncompliance remained and the scope and level remain unchanged.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
02310	Continued From page 93 hospital bed with upper bilateral (two) bed rails raised. The bed rails were secured to the bed frame. On December 3, 2024, at 11:50 a.m., clinical nurse supervisor (CNS)-D stated during bed rail assessments, she checked the bed rails to ensure they were secured, in working order, and still appropriate for use. CNS-D stated she had not completed any zone entrapment measurements nor knew how to measure them. She stated she discussed the risk versus benefits with R1's guardian but did not document the discussion. CNS-D was unaware if there were bed rail assessments to utilize and stated she was "still learning." The surveyor requested nursing assessments that were completed after the initial assessment on February 11, 2024, but CNS-D was unable to locate them. On December 3, 2024, at 2:40 p.m., licensed assisted living director (LALD)-A stated R1's hospital bed and bed rails were not the same bed from before the licensee took ownership of the facility (in February 2024). The hospital bed and bed rails were provided by hospice after R1 was admitted to current licensee. R1 was admitted to the licensee on February 8, 2024, with diagnoses including early onset Alzheimer's disease, urinary incontinence, and aphasia (loss of comprehension and language). R1's service plan created under the former ownership dated July 28, 2021, indicated services included assistance with bathing, dressing and grooming, transfers, laundry, safety checks, wheelchair use, and medication management. R1's Bed Rail Assessment dated May 2, 2022,	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
02310	Continued From page 94 conducted by the previous registered nurse (RN) under the former ownership, included an assessment (purpose and intention of the bed rail) and discussion of risk versus benefit with R1's family. R1's Initial Assessment dated February 11, 2024, by CNS-D indicated R1 used bed rails for bed mobility and repositioning. R1's record lacked: -Reassessment of the bed rail every 90 days, and as needed with a change in condition to include: -purpose and intention of the bed rail; -zone measurements; -resident's bed rail use/need assessment; -risk versus benefits discussion (individualized to each resident's risks); -physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and -any necessary information related to interventions to mitigate safety risk or negotiated risk agreements. The licensee's Side Rail Use policy effective January 24, 2022, indicated before implementing bed rails for a resident, the RN will conduct a bed rail assessment. The RN will document the purpose of the bed rails and the education provided, document the discussion of risks and benefits of using bed rails, and that the RN is responsible to ensure that the bed rails in use are of a safe design and properly maintained. The policy also indicated the bed rail will be used consistent with the manufacturer's recommendations, and the need for bed rails will be reassessed and documented as needed but not less than every 90 days. The policy did not include information about measurement zones of	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
02310	Continued From page 95 entrapment. The Food and Drug Administration (FDA) "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) last updated October 15, 2024, indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment;	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
02310	Continued From page 96 - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements." No further information provided. TIME PERIOD FOR CORRECTION: Immediate	02310		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the required notice was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity. This had the potential to affect all current residents, staff, and any visitors of the licensee. This practice resulted in a level one violation (a violation that has not potential to cause more than	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29038	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTHCARE SERVICES	2925 REGENT AVENUE NORTH CRYSTAL, MN 55422

(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
03090	Continued From page 97 a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The finding include: Upon entrance on December 2, 2024, at 10:30 a.m., an observation outside the front entrance nor entry inside lacked a posted sign at each facility entrance, accessible to visitors that stated, "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." On December 2, 2024, at 11:14 a.m., licensed assisted living director (LALD)-A stated there were no cameras in the home but there was one outside near the front door. She thought since there were no cameras inside, she did not post the notice. On December 3, 2024, at 11:48 a.m., unlicensed personnel/house manager (ULP)-B found the laminated notice with the required language and posted it on the front door. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

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

Type: Full
Date: *12/02/24*
Time: 11:00:00
Report: 1047241338

Food and Beverage Establishment Inspection Report

Location:

Morning Star Healthcare Srvs
2925 Regent Avenue North
Golden Valley, MN55422
Hennepin County, 27

Establishment Info:

ID #: 0037505
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6122208052
ID #:

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

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Hot Water: = at 160 Degrees Fahrenheit
Location: Dishmachine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: Refrigerator- half & half
Violation Issued: No

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

The inspection was completed with the operator and reviewed with MDH nurse evaluator A Bohnen.

The establishment has a residential kitchen. The facility currently has one resident that is not on solid foods, so no food is currently prepared at the facility. The kitchen has wood floors, wood cabinets, solid countertops, painted walls, and painted ceiling.

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

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

If the facility prepares food for residents in the future, they will need
1. A state certified food protection manager (CFPM)
2. A probe thermometer

Food and Beverage Establishment Inspection Report

3.Test strips or thermometers to measure dishmachine temperature

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 1047241338 of 12/02/24.

Certified Food Protection Manager see notes

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed: _____

Anna Bohnen
PIC

Signed: _____

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