



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 25, 2024

Licensee
Daystar Healthcare LLC
2849 108th Lane Northeast
Blaine, MN 55449

RE: Project Number(s) SL39936015

Dear Licensee:

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

The Minnesota Department of Health completed an initial survey on May 29, 2024, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

STATE CORRECTION ORDERS

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

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,



Jessie Chenzie, Supervisor
State Evaluation Team
Email: Jessie.Chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

AH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39936	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/29/2024
NAME OF PROVIDER OR SUPPLIER DAYSTAR HEALTHCARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2849 108TH LANE NORTHEAST BLAINE, MN 55449			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL39936015 On May 28, 2024, through May 29, 2024, the Minnesota Department of Health conducted an initial survey at the above provider, and the following correction orders are issued. At the time of the survey, there were four residents receiving services under the provider's provisional Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 430 SS=A	144G.40 Subd. 2 Uniform checklist disclosure of services	0 430			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39936	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/29/2024
NAME OF PROVIDER OR SUPPLIER DAYSTAR HEALTHCARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2849 108TH LANE NORTHEAST BLAINE, MN 55449			
(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
0 430	Continued From page 1 (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) for one of two residents (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 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:	0 430			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39936	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/29/2024
NAME OF PROVIDER OR SUPPLIER DAYSTAR HEALTHCARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2849 108TH LANE NORTHEAST BLAINE, MN 55449			
(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
0 430	Continued From page 2 R1 was admitted on May 23, 2024, and received services under the licensee's assisted living provisional license. R1's assessment dated May 23, 2024, indicated R1 required assistance with medication management, laundry, housekeeping, bathing, and set up with dressing, and grooming. R1's record respectfully, lacked a service plan and resident agreement by the licensee. In addition, R1's record lacked evidence of a UDALSA by the licensee to include: - a disclosure of the categories of assisted living licenses available and the category of license held by the facility; and - a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide. On May 28, 2024, at 1:03 p.m., clinical nurse supervisor (CNS)-B stated R1 transferred from their other assisted living facility owned by the provider on May 23, 2024. CNS-B stated the same resident agreement, service plan and UDALSA were used from R1's previous assisted living and a new UDALSA had not been completed upon R1's admission. The licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) policy dated June 2021, indicated the licensee would provide a UDALSA to prospective residents prior to signing assisted living contract. The licensee would obtain written acknowledgement from the resident or resident representative that the licensee provided the UDALSA or document the	0 430			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39936	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/29/2024
NAME OF PROVIDER OR SUPPLIER DAYSTAR HEALTHCARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2849 108TH LANE NORTHEAST BLAINE, MN 55449			
(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
0 430	Continued From page 3 reason why an acknowledgement was not obtained. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 430			
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week. This had the potential to affect all four residents residing at the facility.	0 460			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39936	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/29/2024
NAME OF PROVIDER OR SUPPLIER DAYSTAR HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2849 108TH LANE NORTHEAST BLAINE, MN 55449		
(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
0 460	Continued From page 4 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: The licensee held a provisional assisted living facility license and was licensed for a capacity of five residents, with a census four residents residing in the facility. During entrance conference on May 28, 2024, at 10:53 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated the license did not have a system in place for residents to summons staff for assistance; however, provided hourly resident checks. During the facility tour on May 28, 2024, at 11:49 a.m., with CNS-B, no call system was observed in resident rooms to summons staff. During a resident interview on May 29, 2024, at 8:41 a.m., R1 stated the licensee did not provide a call system to summons staff. R1 stated he had a loud voice and would yell out for help if needed. No other information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 460			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39936	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/29/2024
NAME OF PROVIDER OR SUPPLIER DAYSTAR HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2849 108TH LANE NORTHEAST BLAINE, MN 55449		
(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
0 480	Continued From page 5	0 480			
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated May 28, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39936	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/29/2024
NAME OF PROVIDER OR SUPPLIER DAYSTAR HEALTHCARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2849 108TH LANE NORTHEAST BLAINE, MN 55449			
(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 6 (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 interview and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39936	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/29/2024
NAME OF PROVIDER OR SUPPLIER DAYSTAR HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2849 108TH LANE NORTHEAST BLAINE, MN 55449		
(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 7 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's Emergency Preparedness Manual last reviewed April 28, 2024, did not include the following required information: -a hazard vulnerability assessment; -a policy and procedure to address subsistence needs for staff and resident; and -emergency prep testing requirements. On May 29, 2024, p.m., at 3:06 p.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B reviewed the licensee's EPP with the surveyor. CNS-B confirmed the content noted above was missing from the licensee's EPP. CNS-B stated the Hazard Vulnerability Assessment in the licensee's EPP binder was a template and had not been completed. CNS-B was unable to provide documentation to support the licensee participated in an annual full-scale exercise or tabletop emergency exercises and documentation the licensee analyzed the facility's response. The licensee's Emergency Preparedness policy dated August 1, 2021, 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. Per Assisted Living Facilities: Minnesota Rules Chapter 4695, 4659.0100, sections A and B, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39936	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/29/2024
NAME OF PROVIDER OR SUPPLIER DAYSTAR HEALTHCARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2849 108TH LANE NORTHEAST BLAINE, MN 55449			
(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 8 requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents, 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	0 800			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39936	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/29/2024
NAME OF PROVIDER OR SUPPLIER DAYSTAR HEALTHCARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2849 108TH LANE NORTHEAST BLAINE, MN 55449			
(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
0 800	Continued From page 9 or has the potential to affect a large portion or all of the residents). The findings include: On May 29, 2024, at 12:00 p.m., survey staff toured the home with licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B. During the facility tour, survey staff observed the following: 1.The door leading into the attached garage from the home was labeled as an emergency exit on the floor plan. Emergency exits are required to lead directly to the exterior of the building and not through a higher hazard room. During the facility tour interview on May 29, 2024, LALD-A and CNS-B verified the floor plan incorrectly labeled the garage as an exit route. 2. In the basement mechanical room, an extension cord was used as a substitute for permanent wiring for the Levitron component. Improper use of extension cords creates a potential fire hazard. During the facility tour interview on May 29, 2024, LALD-A and CNS-B verified the extension cord was used incorrectly. 3. One downspout was crushed on the end reducing the opening where water drains out for the gutter system installed on the exterior of the home. All components of a gutter system must be maintained to ensure water properly drains away from the basement and foundation of the home. 4. One screen was torn from the frame on the screen porch. During the facility tour interview on May 29, 2024, LALD-A and CNS-B verified the downspout and	0 800			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39936	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/29/2024
NAME OF PROVIDER OR SUPPLIER DAYSTAR HEALTHCARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2849 108TH LANE NORTHEAST BLAINE, MN 55449			
(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
0 800	Continued From page 10 screen porch required repair. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800			
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39936	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/29/2024
NAME OF PROVIDER OR SUPPLIER DAYSTAR HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2849 108TH LANE NORTHEAST BLAINE, MN 55449		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 810	Continued From page 11 drill. This MN Requirement is not met as evidenced by: Based on record review, observation, and interview, the licensee failed to develop a fire safety and evacuation plan with the required content, make the plan readily available, and provide required drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During observation on May 29, 2024, at 1:00 p.m., the surveyor observed the fire safety and evacuation plan was not located in a central location for all staff accessibility, the FSEP was stored in a locked cabinet in the dining room. During an interview on May 29, 2024, at 1:00 p.m., the licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B verified the storage location for the FSEP and stated they did not know the FSEP must be readily available. LALD-A and CNS-B stated a copy of the FSEP would now be kept on the counter in the dining room. On May 29, 2024, at 1:00 p.m., LALD-A and CNS-B provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and employee evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The FSEP included standard employee	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39936	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/29/2024
NAME OF PROVIDER OR SUPPLIER DAYSTAR HEALTHCARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2849 108TH LANE NORTHEAST BLAINE, MN 55449			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 810	Continued From page 12 procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The employee actions were limited to the RACE acronym (Remove, Alarm, Confine, and Evacuate). The FSEP did not identify specific fire protection procedures necessary for residents evident by limited instructions directing residents to stoop or crawl to avoid smoke. The licensee had not developed specific employee actions and resident protection procedures to be taken in the event of a fire or similar emergency. During an interview on May 29, 2024, at 1:00 p.m., LALD-A and CNS-B verified the FSEP lacked the required procedures and stated the plan required revision. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evident by a lack of documentation to support the required number of fire drills had been completed. During an interview on May 29, 2024, at 1:15 p.m., LALD-A and CNS-B verified records to support the required fire drill frequency were not available. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
0 900 SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms	0 900			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39936	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/29/2024
NAME OF PROVIDER OR SUPPLIER DAYSTAR HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2849 108TH LANE NORTHEAST BLAINE, MN 55449		
(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
0 900	Continued From page 13 concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to execute a written assisted living contract with the required content for one of four residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a 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	0 900			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39936	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/29/2024
NAME OF PROVIDER OR SUPPLIER DAYSTAR HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2849 108TH LANE NORTHEAST BLAINE, MN 55449		
(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
0 900	Continued From page 14 limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted on May 23, 2024, and received services under the licensee's assisted living provisional license. R1's diagnoses included diabetes type II, schizophrenic affective disorder, chronic obstructive pulmonary disease, borderline personality disorder, and panic disorder. R1's assessment dated May 23, 2024, indicated R1 required assistance with medication management, laundry, housekeeping, bathing, and set up with dressing, and grooming. On May 28, 2024, at 2:07 p.m., the surveyor observed unlicensed personnel (ULP)-C administering R1's scheduled afternoon medications. R1's record included a service plan and resident agreement dated January 25, 2023, from the licensee's other owned assisted living facility at a different location. On May 28, 2024, at 1:03 p.m., clinical nurse supervisor (CNS)-B stated R1 transferred from their other assisted living facility on May 23, 2024. CNS-B stated the same resident agreement was used at both of their assisted livings; however, the name, address and licensee numbers were different. CNS-B stated a new resident agreement had not been completed at R1's admission and confirmed R1's resident agreement in R1's record was from the another	0 900			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39936	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/29/2024
NAME OF PROVIDER OR SUPPLIER DAYSTAR HEALTHCARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2849 108TH LANE NORTHEAST BLAINE, MN 55449			
(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
0 900	Continued From page 15 assisted living owned by the provider. The licensee's Signing an Assisted Living Contract policy dated June 2021, indicated when a prospective resident decides to move into the licensee, a signed Assisted Living contract would be signed and received by the facility. A copy would be given to the prospective resident and one would be retained in the resident record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900			
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39936	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/29/2024
NAME OF PROVIDER OR SUPPLIER DAYSTAR HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2849 108TH LANE NORTHEAST BLAINE, MN 55449		
(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
01530	Continued From page 16 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 one of two employees (unlicensed personnel (ULP)-C received the required amount of dementia care training in the required time frame. 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: ULP-C had a hire date of January 16, 2024, to provide direct care services to the licensee's residents. On May 28, 2024, at 2:07 p.m., the surveyor observed ULP-C administering R1's scheduled afternoon medications. ULP's employee record contained a training transcript indicating ULP-C completed 2.25 hours out of the required 8 hours of dementia training within 160 hours of the employee's start date. On May 29, 2024, at 9:12 a.m., clinical nurse	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39936	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/29/2024
NAME OF PROVIDER OR SUPPLIER DAYSTAR HEALTHCARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2849 108TH LANE NORTHEAST BLAINE, MN 55449			
(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
01530	Continued From page 17 supervisor (CNS)-B stated employee training was completed through Educare (electronic training program) and the completed training was identified on the employees transcripts. CNS-B reviewed ULP-C's training transcript and stated ULP-C had worked more than 160 hours since employment and ULP-C had not completed the required 8 hours of dementia training. The licensee's Dementia Training policy dated June 2021, indicated all staff of the licensee were required to complete dementia training at the time of hire and annually thereafter. Assisted living licensed facilities for direct care employees would complete 8 hours of initial training within 160 hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530			
01560 SS=D	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	01560			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39936	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/29/2024
NAME OF PROVIDER OR SUPPLIER DAYSTAR HEALTHCARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2849 108TH LANE NORTHEAST BLAINE, MN 55449			
(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 18 training program, the categories of employees trained, the frequency of training, and the basic topics covered. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure dementia training included all the required content for one of two employees (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-C had a hire date of January 16, 2024, to provide direct care services to the licensee's residents. On May 28, 2024, at 2:07 p.m., the surveyor observed ULP-C administering R1's scheduled afternoon medications. ULP-C's employee record lacked evidence ULP-C received the following dementia training: -the explanation of Alzheimer's disease and other dementia; -assistance with activities of daily living; -communication skills; and -person-centered planning and service delivery.	01560			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39936	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/29/2024
NAME OF PROVIDER OR SUPPLIER DAYSTAR HEALTHCARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2849 108TH LANE NORTHEAST BLAINE, MN 55449			
(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 19 On May 29, 2024, at 9:12 a.m., clinical nurse supervisor (CNS)-B stated employee trainings were completed through Educare (electronic training program) and the completed trainings were identified in the employees transcripts. CNS-B reviewed ULP-C's training transcript and stated ULP-C had been assigned the required dementia training topics in Educare; however, ULP-C had not completed all assigned topics. The licensee's Dementia Training policy date June 2021, indicated direct care employees would complete eight hours of initial training within 160 hours of the employment start date. The required dementia care topics would include: -An explanation of Alzheimer's disease and other dementias; -Assistance with activities of daily living; -Problem solving with challenging behaviors; -Communication skills; and -Person-centered planning and service delivery. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01560			
01630 SS=D	144G.70 Subd. 3 Temporary service plan When a facility initiates services and the individualized assessment required in subdivision 2 has not been completed, the facility must complete a temporary plan and agreement with the resident for services. A temporary service plan shall not be effective for more than 72 hours. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01630			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39936	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/29/2024
NAME OF PROVIDER OR SUPPLIER DAYSTAR HEALTHCARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2849 108TH LANE NORTHEAST BLAINE, MN 55449			
(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
01630	Continued From page 20 review, the licensee failed to initiate a temporary 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 was admitted on May 23, 2024, and received services under the licensee's assisted living provisional license. On May 28, 2024, at 2:07 p.m., the surveyor observed unlicensed personnel (ULP)-C administering R1's scheduled afternoon medications. R1's diagnoses included diabetes type II, schizophrenic affective disorder, chronic obstructive pulmonary disease, borderline personality disorder, and panic disorder. R1's assessment dated May 23, 2024, indicated R1 required assistance with medication management, laundry, housekeeping, bathing, and set up with dressing, and grooming. R1's record included a service plan dated January 25, 2023, from the provider's other owned assisted living facility at a different location, which was licensed separately. On May 28, 2024, at 1:03 p.m., clinical nurse supervisor (CNS)-B stated R1 transferred from	01630			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39936	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/29/2024
NAME OF PROVIDER OR SUPPLIER DAYSTAR HEALTHCARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2849 108TH LANE NORTHEAST BLAINE, MN 55449			
(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
01630	Continued From page 21 their other assisted living facility owned by the provider on May 23, 2024. CNS-B stated R1's services remained the same and CNS-B had not completed a new service plan and used R1's service plan from his previous assisted living. The licensee's undated Service Plan policy indicated all resident receiving assisted living services would have a service plan in place. Service plans were based on the outcomes of initial and subsequent assessments, reassessments, monitoring, and individual reviews of the resident's needs and preferences. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01630			
01700 SS=D	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions	01700			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39936	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/29/2024
NAME OF PROVIDER OR SUPPLIER DAYSTAR HEALTHCARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2849 108TH LANE NORTHEAST BLAINE, MN 55449			
(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
01700	Continued From page 22 needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure residents were assessed for self-administration of medications for one of one resident (R1) who self-administered own insulin and inhaler. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included diabetes type II, schizoaffective disorder, chronic obstructive pulmonary disease, borderline personality disorder, and panic disorder. R1's assessment dated May 23, 2024, indicated R1 required assistance with medication administration.	01700			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39936	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/29/2024
NAME OF PROVIDER OR SUPPLIER DAYSTAR HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2849 108TH LANE NORTHEAST BLAINE, MN 55449		
(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
01700	Continued From page 23 R1's Individualized Medication Management Plan dated May 23, 2024, indicated medication self-administration was not applicable and staff were to set up and administer R1's medications. R1's May 2024, Medication Administration Record (MAR) indicated R1 received insulin and inhalers as noted above. R1's record did not include an assessment to determine R1 was able to prepare and self-administer insulin and inhaler safely and appropriately. On May 29, 2024, at 7:27 a.m., the surveyor observed unlicensed personnel (ULP)-C observe R1 check his own blood glucose (sugar) with the FreeStyle Libre sensor (continuously measures glucose levels). ULP-C obtained R1's Basaglar (long-acting) and Fiasp (fast-acting) prefilled insulin pens from the main refrigerator in the kitchen and enter R1's room. ULP-C handed R1 his Basaglar insulin pen and supplies, R1 put the needle on the Basaglar insulin pen, primed the insulin pen two units and dialed the insulin to 45 units. ULP-C verified insulin dosage and R1 self-administered insulin into right lower abdomen. ULP-C handed R1 his Fiasp insulin pen and supplies. R1 applied the needle on the Fiasp pen, primed two units then dialed 32 units of insulin. ULP-C verified the insulin dose and R1 self-administered insulin into right lower abdomen. Immediately following R1's insulin administration observation, ULP-C stated R1 was able to self-administer insulin and staff were verify dose and observe. On May 29, 2024, at 7:55 a.m., the surveyor observed ULP-C hand R1 a clear plastic baggie with Wixela and Incruse Ellipta inhalers (used to	01700			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39936	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/29/2024
NAME OF PROVIDER OR SUPPLIER DAYSTAR HEALTHCARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2849 108TH LANE NORTHEAST BLAINE, MN 55449			
(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
01700	Continued From page 24 treat chronic obstructive pulmonary disease) and R1 self-administered both inhalers. On May 29, 2024, at 9:23 a.m., clinical nurse supervisor (CNS)-B stated directions for self-administration of medications should be indicated on the resident's MAR in Rtasks (electronic charting system). CNS-B viewed R1's MAR in Rtasks and stated directions for self-administration of R1's insulin and inhalers were not indicated in R1's record. CNS-B stated R1 did not have a self-medication administration assessment completed and R1's last assessment dated May 23, 2024, indicated R1 required medication administration assistance. The licensee's Medication Management policy dated August 1, 2021, indicted the licensee would, prior to providing medication management services, have a registered nurse (RN), licensed health professional, or authorized prescriber conduct and assessment to determine what medication management services would be provided and how the services would be provided. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700			
01760 SS=E	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	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39936	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/29/2024
NAME OF PROVIDER OR SUPPLIER DAYSTAR HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2849 108TH LANE NORTHEAST BLAINE, MN 55449		
(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 25 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 the licensee's medication administration procedure was followed and medications were documented after administration for two of two residents (R1, R2) observed during medication administration. 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: The licensee's resident roster provided to the surveyor on May 28, 2024, indicated R1 and R2 received medication administration services. On May 28, 2024, at 2:07 a.m., the surveyor observed unlicensed personnel (ULP)-C remove R1's pre-packaged medications from the locked cabinet, open R1's individual medication pack and pour the two pills into a paper medication cup and administer to R1. ULP-C did not check the	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39936	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/29/2024
NAME OF PROVIDER OR SUPPLIER DAYSTAR HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2849 108TH LANE NORTHEAST BLAINE, MN 55449		
(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 26 instructions on the medication administration record (MAR) in Rtasks (web-based software program) prior to administering R1's medications. ULP-C performed hand hygiene and ULP-C proceeded to remove R2's pre-packaged medications from the medication cabinet, open the pre-filled med pack and put pour one pill into a paper medication cup and administer to R2. ULP-C did not check the medication instructions in Rtasks prior to administering R2's medications. After administering R1 and R2's medications, ULP-C documented in Rtasks both R1 and R2's medications were administered. ULP-C stated she doesn't check the resident's MAR at the time of administering each resident's medications because the medication instructions were written on each individual medication pack. ULP-C stated she usually documented in Rtasks resident medications were administered all at one time and not directly after each resident received their medication. On May 29, 2024, at 9:23 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated staff were trained to check the directions on the residents MAR in Rtasks against the medication label on the prefilled medication packs prior to administering each resident's medications. LALD-A stated staff should check the administered box in Rtasks after each resident's received their medication. The licensee's Medication and Treatment-Administration and Delegation policy dated June 2021, indicated an registered nurse (RN) must instruct the ULP on the following medication administration record (MAR) tasks before delegating the tasks to them: -the complete procedure of checking a resident's medication administration record;	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39936	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/29/2024
NAME OF PROVIDER OR SUPPLIER DAYSTAR HEALTHCARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2849 108TH LANE NORTHEAST BLAINE, MN 55449			
(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 27 -the preparation of medication administration; -the reminder to self-administer medications; and -the documentation after assistance with medication reminder or medication administration, of the date, time, dosage, and method of administration of all medications, and the initials of the nurse or authorized person who assisted or administered and observed the same. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01880 SS=D	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 medications were securely stored and only authorized personnel had access to medication being stored by the licensee for one of one resident (R1) who required medication refrigerator storage. 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	01880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39936	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/29/2024
NAME OF PROVIDER OR SUPPLIER DAYSTAR HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2849 108TH LANE NORTHEAST BLAINE, MN 55449		
(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 28 situation has occurred only occasionally). The findings include: During entrance conference on May 28, 2024, at 10:53 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated the licensee provided secured medication storage. R1's diagnosis included diabetes type II. R1's Individualized Medication Management Plan dated May 23, 2024, indicated R1 received medication administration and the licensee would provide secured storage for all medications. R1's prescriber orders dated January 9, 2024, included Basaglar (long-acting insulin) twice a day and insulin aspart (Fiasp) (fast-acting insulin) three times a day. R1's Medication Administration Record dated May 24, 2024, through May 28, 2024, indicated R1 received Fiasp insulin three times a day and Basaglar insulin twice a day. On May 28, 2024, at 11:51 a.m., CNS-B stated the licensee stored medications that required refrigeration in the main kitchen refrigerator. The surveyor observed the refrigerator with CNS-B whom confirmed storage of R1's multiple unopened boxes of Basaglar and Fisap insulin pens stored in the door of the refrigerator along with one opened Basaglar and one opened Fisap pre-filled insulin pen. CNS-B stated R1's insulins were not stored securely in the main refrigerator and were available for access by unauthorized personnel.	01880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39936	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/29/2024
NAME OF PROVIDER OR SUPPLIER DAYSTAR HEALTHCARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2849 108TH LANE NORTHEAST BLAINE, MN 55449			
(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 29 On May 29, 2024, at 7:27 a.m., the surveyor observed unlicensed personnel (ULP)-C obtain R1's Basaglar and Fiasp insulin flex pens from the main refrigerator located in the kitchen. R1's insulins were stored in the refrigerator door, unsecured. The licensee's undated Medication Storage policy, indicated when medications are managed and stored by the licensee, medications would be kept securely locked and stored per manufacturer directions and only staff would have access to stored medications. 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, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription labels and date time sensitive medications with opened or expiration dates for one of four residents (R1). This practice resulted in a level two violation (a	01890			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39936	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/29/2024
NAME OF PROVIDER OR SUPPLIER DAYSTAR HEALTHCARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2849 108TH LANE NORTHEAST BLAINE, MN 55449			
(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 30 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: On May 28, 2024, at 11:51 a.m., the surveyor observed the medication storage cabinet with clinical nurse supervisor (CNS)-B. CNS-B confirmed the following: R1's opened Wixela and Incruse Ellipta inhalers (used to treat chronic obstructive pulmonary disease symptoms) lacked the original packaging and prescription labels with information regarding the direction for use, medication name, medication dosage, resident's name, and the pharmacy in which it had been issued; and lacked the date the inhalers had been opened and would expire. Immediately following the observation of the medication storage cabinet, the surveyor and CNS-B observed the main refrigerator in the kitchen where resident medications were stored. CNS-B confirmed R1's opened Basaglar (long-acting) and Fisap (fast-acting) pre-filled insulin pens lacked original prescription labels with information regarding the direction for use, medication name, medication dosage, resident's name, and the pharmacy in which it had been issued. CNS-B stated R1's staff were trained to date time-sensitive medication when opened. CNS-B stated medications should have prescription labels or kept in the original packaging labeled by the pharmacy. R1's May 2024, Medication Administration	01890			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39936	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/29/2024
NAME OF PROVIDER OR SUPPLIER DAYSTAR HEALTHCARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2849 108TH LANE NORTHEAST BLAINE, MN 55449			
(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 31 Summary indicated to discard Incruse Ellipta inhaler six weeks after opening. The manufacturer's instructions for Wixela Inhub inhaler dated August 2022, indicated to discard one month after removal of the Wixela inhaler from the foil pouch. The manufacturer's instructions for Incruse Ellipta inhaler dated December 2023, indicated to discard six weeks from the date the Ellipta inhaler had been opened. The licensee's undated Medication Storage policy indicated when medications were managed and stored by the licensee, medications would stored per manufacturer directions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			

Type: Full
Date: 05/28/24
Time: 10:49:06
Report: 1029241169

Food and Beverage Establishment Inspection Report

Page 1

Location:

Daystar Homecare LLC
2849 108th Lane NE
Blaine, MN55449
Anoka County, 02

Establishment Info:

ID #: 0042676
Risk:
Announced Inspection: Yes

License Categories:

Expires on: 12/31/24

Operator:

Phone #: 7633003433
ID #:

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

The following orders were issued during this inspection.

7-200 Toxic Supplies and Applications

7-204.11 **** Priority 1 ****

MN Rule 4626.1620 Discontinue using chemical sanitizers, including chemical sanitizing solutions generated on site and other chemical antimicrobials on food-contact surfaces that do not meet the requirements specified in 40 CFR part 180, section 180.940, or part 180, subpart E, section 180.2020. CHLORINE IN SANIBUCKET >200 PPM. COS TO 50 PPM.

Comply By: 05/28/24

3-500C Microbial Control: date marking

3-501.17A **** Priority 2 ****

MN Rule 4626.0400A Mark the refrigerated, ready-to-eat, TCS food prepared and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded.

NO DATEMARKING ON SHREDDED CHEESE OR SLICED ROAST BEEF.

Comply By: 05/28/24

4-300 Equipment Numbers and Capacities

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

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

SMALL DIAMETER PROBE THERMOMETER NOT PRESENT. INSTRUCTED REP TO OBTAIN THERMOMETER.

Comply By: 05/28/24

Type: Full
Date: 05/28/24
Time: 10:49:06
Report: 1029241169
Daystar Homecare LLC

Food and Beverage Establishment Inspection Report

4-300 Equipment Numbers and Capacities

4-302.14 ** Priority 2 **

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.
CL TEST STRIPS NOT PRESENT. INSTRUCTED REP TO OBTAIN. CL TEST STRIPS PROVIDED
AND PICTURE TAKEN OF COLOR CHART.
Comply By: 05/28/24

4-200 Equipment Design and Construction

4-204.112A

MN Rule 4626.0620A Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.
INTERNAL THERMOMETER PLACED FURTHEST BACK IN CAVITY OF FRIDGE. PLACED IN
DOOR TO OBTAIN FRIDGE'S WARMEST TEMP.
Comply By: 05/28/24

Surface and Equipment Sanitizers

HOT WATER: = at 180 Degrees Fahrenheit
Location: DISHWASHER - THERMAL STICKER
Violation Issued: No

CHLORINE: = >200 PPM at Degrees Fahrenheit
Location: SANITIZER BUCKET
Violation Issued: Yes

CHLORINE: = 50 at Degrees Fahrenheit
Location: SANITIZER BUCKET - REMIX
Violation Issued: No

Food and Equipment Temperatures

Process/Item: MILK
Temperature: 42 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

Process/Item: SHREDDED CHEESE
Temperature: 42 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

Process/Item: ROAST BEEF
Temperature: 42 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

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

SANITIZING, HIGHLY SUSCEPTIBLE POPULATIONS, DATEMARKING, EMPLOYEE ILLNESS
POLICY, AND TEMPERATURE CONTROL DISCUSSED. REFRIGERATOR ADJUSTED TO LOWER
TO AT LEAST 41DF OR LOWER.

Type: Full
Date: 05/28/24
Time: 10:49:06
Report: 1029241169
Daystar Homecare LLC

Food and Beverage Establishment Inspection Report

Page 3

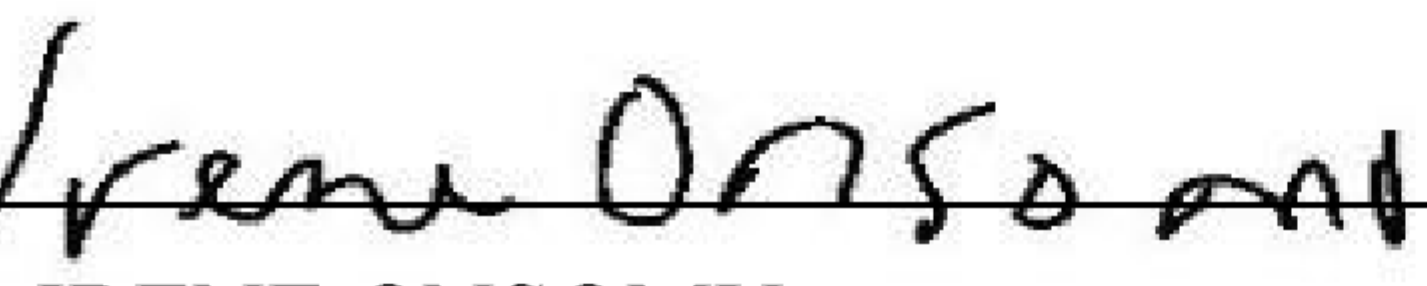
NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1029241169 of 05/28/24.

Certified Food Protection Manager BRENDA K. NYABICHA

Certification Number: FM117608 Expires: 06/30/26

Inspection report reviewed with person in charge and emailed.

Signed: 
IRENE ONSOMU
LALD

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

Report #: 1029241169

m

DEPARTMENT OF HEALTH

Minnesota Department of Health

Food, Pools, and Lodging Services

625 Robert Street North

St. Paul

No. of RF/PHI Categories Out

1

Date

05/28/24

No. of Repeat RF/PHI Categories Out

0

Time In

10:49:06

Legal Authority MN Rules Chapter 4626

Time Out

Daystar Homecare LLC

Address

2849 108th Lane NE

City/State

Blaine, MN

Zip Code

55449

Telephone

7633003433

License/Permit #

0042676

Permit Holder

Purpose of Inspection

Full

Est Type

Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item

Mark "X" in appropriate box for COS and/or R

IN=in compliance

OUT= not in compliance

N/O= not observed

N/A= not applicable

COS=corrected on-site during inspection

R= repeat violation

Compliance Status

COS

R

Supervision

1

IN

OUT

PIC knowledgeable; duties & oversight

2

IN

OUT

N/A

Certified food protection manager, duties

Employee Health

3

IN

OUT

Mgmt/Staff;knowledge,responsibilities&reporting

4

IN

OUT

Proper use of reporting, restriction & exclusion

5

IN

OUT

Procedures for responding to vomiting & diarrheal events

Good Hygienic Practices

6

IN

OUT

N/O

Proper eating, tasting, drinking, or tobacco use

7

IN

OUT

N/O

No discharge from eyes, nose, & mouth

Preventing Contamination by Hands

8

IN

OUT

N/O

Hands clean & properly washed

9

IN

OUT

N/A

N/O

No bare hand contact with RTE foods or pre-approved alternate procedure properly followed

10

IN

OUT

Adequate handwashing sinks supplied/accessible

Approved Source

11

IN

OUT

Food obtained from approved source

12

IN

OUT

N/A

N/O

Food received at proper temperature

13

IN

OUT

Food in good condition, safe, & unadulterated

14

IN

OUT

N/A

N/O

Required records available; shellstock tags, parasite destruction

Protection from Contamination

15

IN

OUT

N/A

N/O

Food separated and protected

16

IN

OUT

N/A

Food contact surfaces: cleaned & sanitized

17

IN

OUT

Proper disposition of returned, previously served, reconditioned, & unsafe food

Compliance Status

COS

R

Time/Temperature Control for Safety

18

IN

OUT

N/A

N/O

Proper cooking time & temperature

19

IN

OUT

N/A

N/O

Proper reheating procedures for hot holding

20

IN

OUT

N/A

N/O

Proper cooling time & temperature

21

IN

OUT

N/A

N/O

Proper hot holding temperatures

22

IN

OUT

N/A

Proper cold holding temperatures

23

IN

OUT

N/A

N/O

Proper date marking & disposition

24

IN

OUT

N/A

N/O

Time as a public health control: procedures & records

Consumer Advisory

25

IN

OUT

N/A

Consumer advisory provided for raw/undercooked food

Highly Susceptible Populations

26

IN

OUT

N/A

Pasteurized foods used; prohibited foods not offered

Food and Color Additives and Toxic Substances

27

IN

OUT

N/A

Food additives: approved & properly used

28

IN

OUT

Toxic substances properly identified, stored, & used

Conformance with Approved Procedures

29

IN

OUT

N/A

Compliance with variance/specialized process/HACCP

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

GOOD RETAIL PRACTICES

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

Mark "X" in box if numbered item is not in compliance

Mark "X" in appropriate box for COS and/or R

COS=corrected on-site during inspection

R= repeat violation

COS

R

Safe Food and Water

30

IN

OUT

N/A

Pasteurized eggs used where required

31

Water & ice obtained from an approved source

32

IN

OUT

N/A

Variance obtained for specialized processing methods

Food Temperature Control

33

Proper cooling methods used; adequate equipment for temperature control

34

IN

OUT

N/A

N/O

Plant food properly cooked for hot holding

35

IN

OUT

N/A

N/O

Approved thawing methods used

36

X

Thermometers provided & accurate

Food Identification

37

Food properly labeled; original container

Prevention of Food Contamination

38

Insects, rodents, & animals not present

39

Contamination prevented during food prep, storage & display

40

Personal cleanliness

41

Wiping cloths: properly used & stored

42

Washing fruits & vegetables

COS

R

Proper Use of Utensils

43

In-use utensils: properly stored

44

Utensils, equipment & linens: properly stored, dried, & handled

45

Single-use/single service articles: properly stored & used

46

Gloves used properly

Utensil Equipment and Vending

47

Food & non-food contact surfaces cleanable, properly designed, constructed, & used

48

X

Warewashing facilities: installed, maintained, & used; test strips

49

Non-food contact surfaces clean

Physical Facilities

50

Hot & cold water available; adequate pressure

51

Plumbing installed; proper backflow devices

52

Sewage & waste water properly disposed

53

Toilet facilities: properly constructed, supplied, & cleaned

54

Garbage & refuse properly disposed; facilities maintained

55

Physical facilities installed, maintained, & clean

56

Adequate ventilation & lighting; designated areas used

57

Compliance with MCIAA

58

Compliance with licensing & plan review

Food Recalls:

Person in Charge (Signature)

Date:

05/28/24

Inspector (Signature)