Electronically Delivered

March 9, 2026

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

RE: Project Number(s) SL35875016

Dear Licensee:

On February 18, 2026, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on December 11, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Tim Hanna, Supervisor
State Engineering Services Section
Email: Tim.Hanna@state.mn.us
Telephone: 507-208-8982 Fax: 1-866-890-9290

CLN

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January 9, 2026

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

RE: Project Number(s) SL35875016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 11, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, 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:

0340 - 144g.30 Subd. 5 - Correction Orders - $500.00
0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 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
	35875	A. BUILDING: _____ B. WING _____	12/11/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL35875016-0 On December 8, 2025, through December 11, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were three residents all of whom received services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag."The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 340 SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever	0 340		

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0 340	Continued From page 1 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 taken to comply with the correction orders from a survey completed February 14, 2024. The lack of action to ensure compliance with regulations had the potential to affect all residents receiving services from the licensee. 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	0 340		

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0 340	Continued From page 2 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 6, 2024, the licensee received results from the previous survey concluded on February 14, 2024. The longest time period for correction (the time frame by which the licensee must document and correct orders) was 21 days from the date the licensee received their results, which was March 27, 2024. The licensee's correction orders included tag identifier 0680, related to 144G.42 Subd. 10. Disaster planning and emergency preparedness plan and 1620 related to 144G.70 Subd.2 (c-f) Initial reviews, assessments, and monitoring. The licensee's undated plan of correction did not include information for tag identifier numbers 0680 and 1620. On December 9, 2025, at 12:44 p.m., clinical nurse supervisor (CNS)-C stated since the previous survey they have been completing assessments a couple days before they are due to make sure they stay compliant. On December 11, 2025, at 10:18 a.m., owner/licensed practical nurse (O/LPN)-A stated prior to the previous survey the licensee's EPP lacked information. O/LPN-A stated after the survey, they added sites to relocate to, folders with resident information, emergency drills and education were completed. O/LPN-A stated the engineer surveyor pointed out some areas on their current EPP that did not meet the	0 340		

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0 340	Continued From page 3 requirements, and they would be adding additional information to their current EPP. O/LPN-A stated after the previous survey, CNS-C started to use a different assessment form that contained all of the information from the uniform assessment tool. The surveyor discussed with O/LPN-A that the plan of correction needed to be documented. O/LPN-A acknowledged their plan of correction did not address 0680 or 1620. During the survey initiated on December 8, 2025, and exited on December 11, 2025, areas of deficient practice related to tags 0680 and 1620 were identified and the correction orders were re-issued. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340		
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,	0 470		

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0 470	Continued From page 4 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 interview and record review, the licensee failed to develop and implement a written staffing plan that included an evaluation completed by the clinical nurse supervisor (CNS) (as indicated in Minnesota Administrative Rule 4659.0180) at least twice a year. 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 December 9, 2025, at 12:40 p.m., owner/licensed practical nurse (O/LPN)-A provided the surveyor with two documents titled Facility Staffing Plan. One was dated January 30, 2025, and one document was not dated. Both documents indicated they were reviewed by	0 470		

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0 470	Continued From page 5 O/LPN-A. The staffing plan indicated there was one direct care staff member from 7:00 a.m. to 7:00 p.m., and one direct care staff member from 7:00 p.m. to 7:00 a.m., Monday through Sunday to meet the needs of the residents. O/LPN-A stated they reviewed the staffing plan twice per year. The surveyor reviewed the statue with O/LPN-A at which time O/LPN-A stated the CNS worked with them to create the staffing plan. The surveyor requested for any additional staffing plan documents that were dated. The surveyor did not receive additional documents prior to the completion of the survey. The licensee's Staffing policy dated January 24, 2022, indicated the CNS would prepare and implement a 24-hour daily staffing plan that ensures adequate staffing to meet residents' needs at all times, including reasonably foreseeable needs. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities.	0 510		

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0 510	Continued From page 6 (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical, and nursing standards for infection control related to hand hygiene for one of two employees (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 December 9, 2025, at 8:55 a.m., the surveyor observed ULP-B retrieve R1 and R4's medication baskets from the medication closet and place them on the kitchen table. ULP-B washed their hands and applied gloves. ULP-B set up and administered R1's medications, documented on the medications administered, picked up the medication cup and placed the cup in R1's medication basket, and moved R1's basket out of view. Without glove removal or performing hand hygiene, ULP-B set up and administered R4's medications. ULP-B then documented on the medications administered, administered one additional medication, placed medication bins for R1 and R4 back into the medication closet,	0 510		

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0 510	Continued From page 7 removed gloves, and washed their hands in the kitchen sink. On December 9, 2025, at 9:13 a.m., ULP-B stated they were trained to retrieve the medication bin, wash their hands, apply gloves, administer medication, return the bin back to the medication cabinet, remove their gloves, and then wash their hands. The surveyor inquired how they were trained to pass medication with two people. ULP-B stated they were trained to only bring one person out at a time due to privacy rights. The surveyor explained how hand hygiene needed to be performed in between residents. ULP-B stated they did not know they needed to perform hand hygiene between the two residents. On December 9, 2025, at 9:16 a.m., owner/licensed practical nurse (O/LPN)-A stated ULP were trained to perform hand hygiene and apply gloves when administering medications. O/LPN-A stated ULP were trained to perform hand hygiene in-between residents with medication administration. The Center for Disease Control and Prevention (CDC) Clinical Safety: Hand Hygiene for Healthcare Workers dated February 27, 2024, recommended hand hygiene should be preformed immediately before touching a patient, after touching a patient or patient surroundings, and immediately after glove removal. The licensee's Infection Control policy dated January 24, 2022, indicated read, "Hands should be washed at the following times. a. After changing beds b. Before assisting with medications c. Before and after treatments d. After all pet care	0 510		

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0 510	Continued From page 8 e. After housekeeping f. After emptying bedpans g. After assisting the resident to the toilet h. After removing items from the floor i. Before preparing food j. Before feeding residents k. After using the bathroom l. After coughing or sneezing m. After smoking n. After handling plants o. After removing gloves". No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 650 SS=D	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		

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0 650	Continued From page 9 screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records included all required content for one of two employees (owner/licensed practical nurse (O/LPN)-A). 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: O/LPN-A was hired on September 14, 2020, under the licensee's previous comprehensive license to provide supervision to unlicensed personnel (ULP) and began providing assisted living services on August 1, 2021. O/LPN-A's record lacked documentation of an annual performance review that identified areas of improvement and training needs and lacked documentation of a review of the licensee's policies and procedures annually. On December 9, 2025, at 1:44 p.m., O/LPN-A stated, "I don't have and evaluation. [clinical nurse supervisor (CNS)-C] should have evaluated	0 650		

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0 650	Continued From page 10 me." On December 9, 2025, at 2:17 p.m., O/LPN-A stated they did review the licensee's policies and procedures, however, was unable to find the documentation. The licensee's Personnel Records policy dated January 24, 2022, indicated all records of annual training and performance reviews would be kept in the personnel record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (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	0 680		

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 680	Continued From page 11 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 maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. 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 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's undated EPP binder titled [the licensee's name] Emergency Preparedness Manual lacked evidence of the following required content: - annual update; - considered emerging infectious diseases; - strategies for addressing facility and community-based risks including staffing shortages; - quarterly missing resident plan review; - subsistence needs for staff and residents; - procedure of transportation in the event of evacuation;	0 680		

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0 680	Continued From page 12 - policies and procedures for volunteers; - memorandum of understanding with the alternative place of evacuation; - roles under a waiver declared by secretary; - names and contact information; - emergency contact information; and - methods for sharing information. On December 10, 2025, at 1:39 p.m., owner/licensed practical nurse (O/LPN)-A stated they reviewed the EPP twice per year and the review was documented in the EPP. The surveyor stated there were no review dates in the binder. O/LPN-A acknowledged there was no review date located within the EPP binder. O/LPN-A stated they reviewed the missing resident plan two times per year and the licensee had not had an issue with elopement. O/LPN-A stated in an evacuation, residents would be transported in a staff member's car, and if there was not enough room, they would uber (a transportation company). O/LPN-A stated residents would evacuate to another assisted living they owned and if they were unable to go there, residents would go to a Motel 6. O/LPN-A stated they did not have an agreement with the Motel 6 because they would not need to use the motel unless they no longer owned the other assisted living facility. O/LPN-A did not know what a waiver declared by secretary was when questioned how they met the requirement. O/LPN-A stated telephone numbers were not included in the EPP binder because they were programmed into phones and hanging on a wall located within the assisted living. The licensee's Emergency Preparedness Plan policy dated January 24, 2022, indicated the licensee would have an identified plan in place to assure the safety and well-being of resident and staff during periods of emergency or disaster that	0 680		

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0 680	Continued From page 13 disrupts service. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=H	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated 12/12/2025, for the specific violations related the physical environment under Minnesota Statute 144G.	0 775		

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0 775	Continued From page 14 TIME PERIOD FOR CORRECTION: Two (2) days	0 775		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	0 810		

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0 810	Continued From page 15 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated 12/12/2025, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 940 SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide	0 940		

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0 940	Continued From page 16 customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with all required content. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that will cause only minimal impact on	0 940		

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0 940	Continued From page 17 the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's blank Assisted Living Contract included Exhibit 4 Minnesota Medical Assistance Program. The document included fill in the blank sections to document the following: - housing support services rate/month; - resident portion; - damage deposit; - programs covering services; - rate/day; and - additional service fees/service plan (s). In addition, it included the following statements: - housing support services can pay up to 18 days per episode of absence not to exceed 60 days in a calendar year, if the person is away from the establishment but expects to return; and - the licensee verifies that at least 194 dollars per month was spent for the purchase of food for each housing support recipient. The Assisted Living contract lacked the licensee's information on a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: - whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; - whether the facility has an agreement to provide housing support under section 256I.04 sub. 2 paragraph (b);	0 940		

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0 940	Continued From page 18 - whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program and if so the length of time that private pay is required; - a statement that medical assistance waivers provide payment for services but do not cover the cost of rent; -a statement that resident may be eligible for assistance with rent through the housing support program; and - a description of the rent requirement for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program. On December 9, 2025, owner/licensed practical nurse (O/LPN)-A stated the facility accepted community access for disability inclusion (CADI) wavier, elderly waiver, and private pay. O/LPN-A stated they did not know about the requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 940		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on	01620		

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01620	Continued From page 19 which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) 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. (f) 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.	01620		

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01620	Continued From page 20 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed ongoing resident reassessments that did not exceed 90 days for two of three residents (R1, 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 a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1 admitted to the licensee on July 13, 2021, and began receiving assisted living services. R1's diagnoses included alcohol use disorder, hypertension, and depression with anxiety. R1's Service Plan dated July 16, 2025, indicated R1 received reminders for dressing, grooming, meals, medication administration, and behavior management. R1's record included ongoing 90-day assessments dated January 17, 2025, July 12, 2025, and October 10, 2025, which indicated 176 days passed between the January and July assessments.	01620		

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01620	Continued From page 21 R2 R2 admitted to the licensee on February 5, 2025, and began receiving assisted living services. R2's diagnoses included schizophrenia, gout, delirium, cannabis abuse, and stimulant abuse. R2's Service Plan dated February 2, 2025, indicated R2 received reminders for dressing, grooming, meals, medication administration, and behavior management. R2's record included ongoing 90-day assessments dated May 18, 2025, August 18, 2025, and November 15, 2025, which indicated 92 days passed between the May and August assessments. On December 9, 2025, at 12:44 p.m., clinical nurse supervisor (CNS)-C stated ongoing assessments were completed every 90 days. CNS-C stated since the previous survey they had been completing assessments a couple days before they were due to make sure they stayed compliant. CNS-C stated they believed R1 had another assessment in between the January assessment and July assessment, which the surveyor asked them to provide. CNS-C stated R2's assessments should be in range unless they miscalculated the date. The surveyor did not receive any further assessments for R1 prior to concluding the survey. The licensee's Assessment - Comprehensive Services dated July 11, 2020, indicated ongoing resident monitoring and reassessment must be conducted as needed based on changes in the needs of the resident, but cannot exceed 90 days from the last date of assessment.	01620		

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01620	Continued From page 22 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse 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 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,	01730		

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01730	Continued From page 23 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 maintain a current individualized medication management record for each resident to include all required content for three of three residents (R1, R2, R4). 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: R1 R1 admitted to the licensee on July 13, 2021, and began receiving assisted living services. R1's diagnoses included alcohol use disorder, hypertension, and depression with anxiety.	01730		

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01730	Continued From page 24 R1's Service Plan dated July 16, 2025, indicated R1 received reminders for dressing, grooming, meals, medication administration, and behavior management. On November 8, 2025, at 11:51 a.m., the surveyor observed a Ventolin hydrofluoroalkane (HFA) inhaler on R1's bedside table. Owner/licensed assisted living director (O/LPN)-A stated R1 self-administered their inhaler. R1's medication administration record (MAR) included the following orders: - triamcinolone 0.5 percent (%) cream apply to the skin twice daily; and - Ventolin HFA inhaler inhale 1 to 2 puffs by mouth as needed (PRN) for cough, shortness of breath, or wheezing. The MAR did not indicate where triamcinolone 0.5 % cream would be applied and did not indicate when one puff vs two puffs of Ventolin should be administered. The MAR indicated the Ventolin HFA inhaler was administered by unlicensed personnel (ULP). R1's Medication Management Plan dated July 16, 2025, indicated R1 required medication set up services by a nurse weekly, medications were administered as scheduled by ULP and licensed practical nurse (LPN), registered nurse (RN) and LPN would monitor prescription refills, medications where stored in a cabinet double locked and refrigerator, and ULP should notify a nurse with side effects, refusal of medications, and any concerns. R1's Nurse Reassessment dated October 10, 2025, indicated all medications were centrally locked, and R1 needed assistance with medication set up and administration.	01730		

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01730	Continued From page 25 R1's medication management plan comprised of multiple documents lacked the following: - specific written instruction for the resident's medication administration; - medication management tasks that may be delegated to ULPs; and - an accurate plan for medication storage. R2 R2 admitted to the licensee on February 5, 2025, and began receiving assisted living services. R2's diagnoses included schizophrenia, gout, delirium, cannabis abuse, and stimulant abuse. R2's Service Plan dated February 2, 2025, indicated R2 received reminders for dressing, grooming, meals, medication administration, and behavior management. R2's Medication Management Plan dated February 10, 2025, indicated R2 required medication set up services by a nurse weekly, medications were administered as scheduled by ULP and LPN, RN and LPN would monitor prescription refills, medications were stored in a cabinet double locked and refrigerator, and ULP should notify a nurse with side effects and refusal of medications. R2's Nurse Reassessment dated November 15, 2025, indicated all medications were secured, R2 needed assistance with medication set up and administration. R2's medication management plan comprised of multiple documents lacked medication management tasks that may be delegated to ULPs.	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35875	A. BUILDING: _____ B. WING _____	12/11/2025

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

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01730	Continued From page 26 R4 R4 admitted to the licensee on July 25, 2024, and began receiving assisted living services. R4's diagnoses included schizophrenia (mental disorder marked by significant impairment in how reality is perceived leading to symptoms such as hallucinations, delusions, and disorganized thinking), cannabis use disorder, and multiple suicidal attempts. R4's Service Plan signed July 25, 2024, indicated R4 received reminders for grooming and meals and assistance for dressing, medication administration, and behavior management. R4's MAR dated December 1, 2025, through December 31, 2025, included antacid anti-gas suspension 10 milliliters (ml) to 20 ml by mouth four times a day as needed for stomach discomfort. The MAR did not indicate when 10 ml verses 20 ml would be administered. R4's ongoing assessment dated October 20, 2025, indicated R4 required medication set up and administration. R4's Medication Management Plan dated July 24, 2025, indicated medication was set up by the RN and LPN weekly, medication administration was completed per schedule by ULP and LPN, monitoring was completed by the RN and LPN daily and as needed, medications were stored in a cabinet and doble locked as needed, and ULP should notify a RN with side effects and refusals of medications. R4's medication management plan comprised of multiple documents lacked the following:	01730		

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01730	Continued From page 27 - specific written instruction for the resident's medication administration; and - medication management tasks that may be delegated to ULPs. On December 9, 2025, at 12:58 p.m., the surveyor inquired if they documented what medication management tasks were delegated to the ULPs. Clinical nurse supervisor (CNS)-C stated, "I have not done that in the past. Most of the meds are administered by them [ULP] anyways. The nurses are not there to administer medications." CNS-C acknowledged R1 and R4's records lacked specific instructions for medication administration and stated they would ask the prescriber for more specific administration instructions on the medications listed above. The licensee's Service Plan for Medication Management dated January 24, 2022, read, "1. The written Medication Management Plan includes the following provisions. a. A statement describing the medication management services to be provided b. A description of the storage of medications based on the resident assessment* and addressing i. Resident preference ii. Risk of diversion iii. Instructions per manufacturer c. documentation procedures d. Procedures for medication reconciliation* e. Identification of person(s) responsible for monitoring medication supplies and ensuring refills are ordered/timely f. Description of medication management tasks to be delegated to unlicensed personnel	01730		

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

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01730	Continued From page 28 g. Plans for staff notifying the licensed health professional when/if a problem with medication management services arises h. Any resident-specific requirements related to documenting medication administration, verification that all medications are administered as prescribed and monitoring of medication use to prevent possible complications or adverse reactions." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01760 SS=D	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 administer medication as prescribed for one of three	01760		

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	35875	A. BUILDING: _____ B. WING _____	12/11/2025

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

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01760	Continued From page 29 residents (R4). 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: R4 admitted to the licensee on July 25, 2024, and began receiving assisted living services. R4's diagnoses included schizophrenia (mental disorder marked by significant impairment in how reality is perceived leading to symptoms such as hallucinations, delusions, and disorganized thinking), cannabis use disorder, and multiple suicidal attempts. R4's Service Plan signed July 25, 2024, indicated R4 received reminders for grooming and meals and assistance for dressing, medication administration, and behavior management. R4's Medication List signed May 21, 2025, included the following order: vitamin D3 25 microgram (mcg) tablet take two tabs once per day. R4's medication administration record (MAR) dated December 1, 2025, through December 31, 2025, indicated R4 received nine pills (eight medications) administered by staff at 8:00 a.m., which included pantoprazole 40 milligrams (mg) one tablet, haloperidol 5 mg one tablet, vitamin	01760		

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	35875	A. BUILDING: _____ B. WING _____	12/11/2025

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01760	Continued From page 30 D3 25 micrograms (mcg) two tablets, lisinopril 20 mg one tablet, benztropine 1 mg one tablet, famotidine 40 mg one tablet, amlodipine 10 mg one tablet, and metoprolol succinate extended release (ER) 50 mg one tablet. On December 9, 2025, at 9:03 a.m., the surveyor observed ULP-B count eight pills in the Medi planner, count out loud eight different medications from the MAR, place the eight pills into a medication cup, administer the eight pills to R4, and document all eight medications as being received on the MAR. The surveyor showed ULP-B that per the MAR, R4 was supposed to receive nine pills and inquired which medication was missing from the medication set up. ULP-B stated they followed the MAR however; they did not see that one medication required two pills. Owner/licensed practical nurse (O/LPN)-A joined the conversation and stated it was R4's vitamin D. The surveyor observed the nurse look in Wednesday's morning medication set up which also contained eight pills instead of nine pills. O/LPN-A stated, "it is my fault" they were set up incorrectly. O/LPN-A put one more vitamin D 25 mcg pill into a medication cup and handed it to ULP-B. ULP-B called R4 back to the kitchen and administered one pill of vitamin D 25 mcg to R4. The licensee's Medication Administration policy dated July 11, 2020, indicated residents are entitled to the safe administration of medications by qualified personnel according to a written medication management plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		

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01890	Continued From page 31	01890		
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 discard expired medication for one of three residents (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: R2's Service Plan dated February 2, 2025, indicated R2 received reminders for dressing, grooming, meals, medication administration, and behavior management. On December 8, 2025, at 11:45 a.m., the surveyor observed the licensee's locked medication cabinet where unlicensed personnel (ULP) dispensed medication from and observed the following expired medications: - R2 acetaminophen 325 milligrams (mg) with an	01890		

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01890	Continued From page 32 expiration date of July 7, 2025; and - R2 methocarbamol 500 mg with an expiration date of July 7, 2025. Owner/licensed practical nurse (O/LPN)-A stated they removed expired and discontinued medications from the medication closet monthly and the medication listed above "slipped through the crack". O/LPN-A stated the medications listed above should have been destroyed. The licensee's Disposition and Disposal of Medication policy dated January 24, 2022, indicated expired medications would be disposed of according to this policy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

MORNING STAR HEALTH CARE SER
6400 Georgia Avenue North
Minneapolis, MN 55428
Hennepin County
Parcel:

Phone:

License Info

License: HFID 35875

Risk:
License:
Expires on:
CFPM: Precious Ojika
CFPM #: FM18517; Exp: 12/13/2026

Inspection Info

Report Number: F1039251226
Inspection Type: Full - Single
Date: 12/9/2025 Time: 10:00
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

MILK - COLD HOLD, KITCHEN REFRIGERATOR - 40 DEGREES F
AMBIENT - GARAGE REFRIGERATOR - 35 DEGREES F
FREEZERS - FROZEN

This inspection was completed as part of MDH HRD assisted living facility survey. The inspection was conducted with the person-in-charge and reviewed with MDH HRD nurse evaluator Ashley Crews.

The kitchen is of residential build and should serve food for same-day service only. Kitchen equipment and facilities, including wooden cabinets with hollow base, are in good repair.

A 2-compartment sink is present in kitchen. 1 compartment is designated for handwashing only.

Log of dishwashing machine rinse temperature shows utensil surface temperature >170 degrees F.

Verified hand sink correctly set-up, gloves, illness policy, probe thermometer, UST thermometer.

Discussed the following with the person-in-charge: minimum cook temps for animal proteins, food source, foodborne illness symptoms and exclusion of ill employees, avoiding bare hand contact with ready to eat foods, handwashing and sanitizing.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Metro District Office inspection report number F1039251226 from 12/9/2025

Precious Ojika
person-in-charge

Aron Goodner,
Public Health Sanitarian 1
651-201-4910

aron.goodner@state.mn.us

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Sanitizer Observations/Recordings

Establishment Info

MORNING STAR HEALTH CARE SER
Minneapolis
County/Group: Hennepin County

Inspection Info

Report Number: F1039251226
Inspection Type: Full
Date: 12/9/2025
Time: 10:00

Sanitizing Chemical: **Product:** Chlorine**; Sanitizing Process:** Wiping Cloth Bucket
Location: bucket with lid under kitchen sink **Equal To** 200 PPM
Comment: made daily
Violation Issued?: No

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL35875016-0	**Date:** 12/12/2025
Facility Name: Morning Star	
Facility Address: 6400 Georgia Avenue N., Minneapolis, MN 55428	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 3; Pattern **TIME PERIOD OF CORRECTION:** Two (2) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]

2. Required egress window openings in rooms of care facilities licensed or registered by the state of Minnesota shall have a minimum net clear opening area of 4.5 square feet (648 square inches). Opening height and width dimensions shall not be less than 20 inches. The net clear opening dimensions shall be the result of normal operation of the opening. [Minn. Stat. 144G.45 subd. 2; MSFC 1104.26.2, 1104.26.6.1]

   Comments: Resident bedrooms three and four had casement style windows that hit the exterior awning when M-E tried to open them. The windows would not open more than 16 ½" wide.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Twenty One (21) days

1. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include employee actions to be taken in the event of a fire or similar emergency. [Minn. Stat. 144G.45 subd.2]

   Comments: The FSEP provided to the surveyor did not include employee actions for evacuating residents during fire or similar emergency. The facility had the RACE acronym posted on the wall, but it did not provide instructions for how staff are to complete each step.

2. Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. [Minn. Stat. 144G.45 subd.2]

   Comments: O/LPN-A stated the facility conducts two drills per year and provided the surveyor with drill reports dated 1/30/2025 and 7/29/2025.